Planning for Humanity: An Urban Planning Perspective on Mental Illness, Deinstitutionalization and Supportive Housing in New York City

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Abstract

I set out to prove that deinstitutionalization caused a grand dis-service to the mentally ill, leaving many individuals homeless and without proper care. It was my intention to prove that while they were improperly resourced, institutions served a purpose in society. Public perception and politics played large roles in the inefficiencies of resourcing institutions and subsequent housing and housing programs for the mentally ill and mentally ill homeless. The nexus between mental illness and homelessness has been proven time and again in scholarly literature, however the nexus between deinstitutionalization and an *increase* in homelessness is tenuous. Though it is clear that deinstitutionalization highlights a distinct gap in service provision and housing which led to homelessness. The literature documents difficulties in housing mentally ill persons throughout the decades and also the significance in recent spikes in mentally ill homeless. Through the collection of oral histories, I have deduced that an area in which future planners should do more research is on the effects of supportive housing programs on the communities in which they are developed. Perhaps by highlighting the ways in which engaging in mental illness services and resources as a community, we may find a way to reduce or even remove the stigma which has plagued individuals with mental illness for centuries.

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I would be remiss if I didn't thank my mom, my family and my friends for their patience as well. Without their continuous support I would not only not be completing this degree or this paper, but I might not have pursued this course in life. Mental health is a challenge of balancing your inner voice and the influencing voices around you, I am lucky that the people who surround me are loving and supportive, intelligent and honest.

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Introduction

In an effort to develop healthier cities, urban planners focus on all of the elements that create an urban environment. This paper will focus on the smallest unit of those elements, the individual. An urban center is, in essence, a conglomeration of individuals that create an urban space. The aim of this paper is to analyze the successes and failures of public policies in relation to the provision or inability to provide adequate care for mentally ill individuals who do not have the means to afford healthcare. In particular, as it relates to planning, those individuals are the mentally ill homeless who are either unaware or incapable of seeking aid or treatment through any other means than the service provisions through policy or philanthropic efforts. My hypothesis at the outset of this research was the postulation that deinstitutionalization had expansive impacts on the lives of mentally ill persons causing many of these individuals to lose stable housing. Through this hypothesis I was hoping to discover where and how planning, as a professional field, fit into the equation. In my opinion there has never been a question of whether or not this is a "planning issue." I assumed that the answer to deinstitutionalization was a recreation of institutions; a creation of better resourced and managed facilities with all the proper services and amenities. I also assumed that planning had played a small role (based upon the lack of literature) in the aftermath of deinstitutionalization. However, the existing literature and oral histories I have collected from professionals working at the intersection of mental healthcare and housing, have challenged my assumptions, both about deinstitutionalization and the implications of planning.

The nexus between mental illness and homelessness has been drawn time and again (Turnbull et al., 2007; Bassuk et al., 1984; Sullivan et al., 2000; Hopper et al., 1997; McCollough, 1974; Polak and Warner, 1996; Sisti et al., 2015; Parcesepe and Cabassa, 2012; Sosin and Grossman, 1991; Roberts and Kurtz, 1987). However, the connection between deinstitutionalization of mentally ill persons and homelessness is more tenuous, or rather more circuitous. I maintain that there is a connection between deinstitutionalization and an increased presence of mentally ill persons on the street, but it is due more to a lack of available resources or the challenges connected to attaining resources than the direct closure of mental health institutions. The issue of homelessness is an exquisite example of a systemic issue entrenched in the ecosystem of policy, education, public services and programs, and social behavior. This list is as large as your imagination in parsing out the individual aspects of a society. An attempt to isolate one potential area of homelessness (i.e. mental health), is as difficult as identifying the sequence of the chicken and the egg. Many studies have shown that living with mental illness can lead to chronic homelessness or housing instability (Novella, 2010; McCollough, 1974; Roberts and

Kurtz, 1987). There are also studies (less proven, but existent) which show that urban homelessness begets mental illness (Lederbogen et al., 2011).

The absence of literature pertaining to homelessness and mental illness as written by planners compelled me to read a collection of studies and literary works by sociologists, psychiatrists, public health professionals, and philosophers. This hole in the research and literature is one of the ways in which my assumptions about the implications of planning have changed. It urged me to find a foothold for planners who might be interested in researching or engaging in the world of mental illness and healthcare. After conducting the interviews, I was presented with a potential solution. I would encourage future studies to analyze the effects of supportive housing on the community in which they are developed, thus giving supportive housing a cogent base to propagate future developments.

Cities are constantly innovating and reinventing ways to manage and house their mentally ill homeless population. New York City is one of the oldest cities in the United States and is internationally recognized as the port to the States. As such it has seen an ever-growing, ever-changing population. In a city as large and established as New York, housing the general population proves challenging, but New York is exemplary in discovering ways to house its citizens. With regard to the mentally ill homeless, New York has played host to innovations in this arena. For this reason, New York is an excellent case study as an urban center in the fight to reduce homelessness of the mentally ill and for the general population.

Historical Context

Mental healthcare in the United States and abroad is wrought with controversy and embedded in the political dissent between the Right (Republican) and the Left (Democrat). Prior to 1840, individuals could be committed against their free will for conditions that we would view today as not worthy of institutionalization. For example, women could be committed to an asylum for menstruation-related anger, disobedience, and postpartum depression. At this time, insane asylums were also home to individuals living with physical disabilities as minor as a cleft palate and mental disabilities such as Autism and Down's Syndrome. This multitude of individuals suffering from a variety of ailments, conditions, illnesses, and disabilities were living in large “hospitals,” where they were often chained to their beds and tightly packed side-by-side. The first state mental hospital, Virginia’s State Lunatic Hospital, was established in 1733 in Williamsburg, Virginia and was exclusively for the severely mentally ill. It was funded wholly through state funds (Deutsch, 1949). Five decades after this first state institution opened, more states followed Virginia’s example and opened their own state mental

asylums. The movement began in 1822 in Kentucky and led to the development of nine more state mental institutions by 1842 (Deustch, 1949). Many of these facilities gathered their patients from correctional facilities where these individuals had been housed alongside alleged criminals. The hope was that these hospitals would help "paupers and lunatics" recover from what ailed them, rather than the usual practice of incarceration or sale of insane people at auction (Deustch, 1949).

Despite the efforts of state mental hospitals to improve the wellbeing of the mentally ill, it was no secret that these institutions were "out of home" disappointments' rooms[1]. These facilities were notoriously underfunded. In the 1840s, Dorothea Dix, a devoted activist in the United States lunacy movement (the first mental health reform movement), lobbied Congress to pass legislation that would have required states to allocate more funding to the development of more facilities. However, this was not passed as President Pierce did not believe it was for the federal government to decide the care for the mentally ill (Roberts and Kurtz, 1987). Dix was able to encourage the development of 32 more state institutions. Unfortunately, these institutions also became overpopulated and were unable to provide adequate care. They became seen as holding sites for immigrants and the disabled elderly (Roberts and Kurtz, 1987).

At the turn of the century (1900), mental healthcare saw another push for reform when services in the original institutions began to deteriorate, causing patients to often be treated less than humanely. Clifford Beers was the spearhead for this reform movement (Roberts and Kurtz, 1987). Beers, a former resident of one of the state mental institutions, published an autobiography (1908) outlining his mistreatment at the large state facilities. This launched an advocacy movement known as the "Mental Hygiene Movement." Beers "advocated for higher salaries and improved living conditions for attendants hoping that persons with a more humane and sensitive outlook would become interested in working in an asylum" (p. 81 Roberts and Kurtz). His honest account of the maltreatment he experienced in a state mental institution led to the formation of the National Committee for Mental Hygiene, known today as Mental Health America, and advocates for mental healthcare reform on a national level (Mental Health America, 2017). Advocates like Beers championed community-based mental healthcare support and fostered the environment in which planners could more readily make a difference. In 1946 under President Truman, The National Mental Health Act was passed; it authorized $7.5 million dollars to target three primary purposes. One of these purposes was for grants and fellowships awarded to public

[1] Disappointments rooms were primarily found in North America. They were small spaces usually located at the top floor of a house where families would keep family members (usually children) suffering from mental or physical disabilities or illness from the public eye.

and private non-profit institutions for the prevention and diagnosis and treatment of neuropsychiatric disorders (Roberts and Kurtz, 1987). This was the first-time federal funds were allocated to the care of mentally ill persons, and the act redirected the funding and oversight of mental health from the state to the federal level. Concurrently, President Truman also signed into law the Housing Act of 1949, the first meaningful housing act to date which mandated the elimination of substandard housing through slum clearance. This was effectively the start of Urban Renewal. Housing of a higher standard was intended to accompany this mass demolition of housing; however, it was never truly fulfilled.

In the 1960s, President John F. Kennedy was the first President to speak out in defense of legislation for mental health and illness in his speech "a bold new approach." In 1963, he signed the Community Mental Health Act, which provided federal funding for the construction of community-based preventative care and treatment facilities; a comprehensive community care approach. It was one of the first, and most important, steps in passive deinstitutionalization which is the precursor to the formally recognized deinstitutionalization (Roberts and Kurtz, 1987). The community health centers that arose from Kennedy's proposal were a notable step towards providing public mental health services through the provision of outpatient care and partial hospitalization services. They operated under the functioning model of the Continuum of Care. This model of care put the primary focus on the provision of healthcare; "It begins with outreach, includes treatment and transitional housing, and ends with permanent supportive housing" (p. 651, Tsemberis et al., 2004). It increased the number of people receiving care from 1.7 million to 6.9 million between 1955 and 1977 (Roberts and Kurtz, 1987). The Community Mental Health Centers (CMHC) "were responsible for 32 percent of patient care in contrast to none in 1955" (p. 85 Roberts and Kurtz, 1987). However, critics of this legislation argue that it was more ideological than political in its approach and that service provision was not adequately resourced for the patients being released to the CMHCs. This caused many individuals in need of care to receive inadequate or little service support (Roberts and Kurtz). After JFK's assassination in November 1963, Vice President Lyndon B. Johnson became the President. This shift in Presidential control may have contributed to the failures in the policy. President Johnson was presented with a nation that had a 19% national poverty rate and thus started his War on Poverty. Interestingly, the policies enacted by Johnson should have had a positive impact on CMHCs as they would have increased financial support, but did little to help CMHC program success, perhaps this is because his policies were also viewed as having little to no public support. Concurrently, the act and policies received inadequate funding, due to the Recession of the 1980s and the Vietnam War.

President Carter was in office when the Housing and Community Development Amendments of 1978 were passed by Congress. These amendments were to the original Housing Act, which the Department of Housing and Urban Development (HUD) were now responsible for enforcing. Created by these amendments was the Housing Choice Voucher program, otherwise known as Section 8, which is a rent subsidy program for eligible low- and moderate-income families who want to rent housing in the private market in which "HUD provides a subsidy sufficient to reduce the recipient's rental payment to 30 percent of income" (p. 174 Newman et al., 1994). Section 8 proves to both be helpful and harmful to the mentally ill homeless. To qualify for Section 8 funds a person must meet four standards, one of which indicates that a disability (not specifically named) will qualify a person; but if a person has been evicted previously then they will not be granted Section 8 assistance. As will be discussed in greater detail, stigma and landlord discrimination can greatly impact a renter's ability to remain in permanent housing and could therefore impact eligibility for Section 8 assistance (Hurlburt et al., 1996). Furthermore, Section 8 is contingent upon the presence of affordable, higher quality housing (Newman et al., 1994). In response to the failings of his successors in regard to direct aid for the mentally ill, President Jimmy Carter signed the Mental Health Systems Act in 1980 in an effort to restructure the Community Mental Health Act and increase federal aid.

This was then overturned by President Reagan in the following year. The Reagan Administration's Omnibus Reconciliation Act of 1981 which cut the allocation of federal money in favor of block grants provided to the states led to an immense scarcity of resources, including the number of skilled professionals available to provide care to patients who only had access to public facilities. Insurance companies and funders were more likely to approve inpatient care over outpatient care which led to a gradual decline in the use of outpatient services such as CMHCs (Roberts and Kurtz, 1987). Omnibus was the start of deinstitutionalization as an official policy movement. Deinstitutionalization caused the closures of psychiatric institutions across the nation. In tandem to deinstitutionalization there was seen an increasing presence of mentally ill persons on the streets, in hospitals, and in the jails and prisons.

Shortly after deinstitutionalization occurred there was a "growing visibility of the homeless on our city streets" (p. 1546 Bassuk et. al, 1984). There were several explanations for this marked increase, such as increased unemployment, the economic recession, and the unavailability of low-cost housing options. According to Bassuk et. al, "clinical reports suggest that the homeless population began to change in the early 1970s to include a greater number of mentally ill individuals and that a significant population had been hospitalized for psychiatric care" (p. 1549 Bassuk et. al, 1984). This coincided with

the start of passive deinstitutionalization through policies supporting community-based healthcare and the removal of involuntary commitment to institutions, as well as innovations in medicine with the introduction of Thorazine, the "wonder drug" which placated individuals suffering from serious mental illnesses like schizophrenia and lesser severe forms of mental illness such as bipolar disorder, into a quiet stupor. Shorter stays for inpatient care led to increased risk of a patient becoming "psychotic" upon release and subsequent loss of housing or access to stable housing (p. 1549 Bassuk et. al, 1984). The growing number of shelters after the policy reforms of the 1980s were also indicative of the possibility that there was a relationship between release of mentally ill individuals and increased homelessness. Shelters had "become 'open asylums' to replace the institutions" (p. 1549 Bassuk et. al, 1984). Bassuk et. al found their data to "support the likely hypothesis that the homeless mentally ill are more disconnected from support networks than are those with a home" and are therefore more likely to require aid from public and private philanthropic entities (p. 1549 Bassuk et. al, 1984).

This assertion that the increase in homelessness, in particular mentally ill homeless persons, has been caused by deinstitutionalization was contested in a recent interview with Dr. Kim Hopper, a medical anthropologist and professor of Clinical Socio-medical Sciences at the Columbia University Mailman School of Public Health. He has been working in both mental health and homeless advocacy since the late 1970s. His ethnographic and historical research on psychiatric care and on homelessness in New York City will be reviewed later in this paper. Dr. Hopper believes that deinstitutionalization did not cause the great number of mentally ill persons we see on the streets today. He also asserts that deinstitutionalization is on-going, rather than a one-time event that occurred in the past. There is an "institutional circuit" of mental hospitals, prisons, jails, halfway houses, etc. and mentally ill homeless persons often move transitionally throughout this circuit. He also believes that the goal of reducing homelessness can only be met through consistent housing. Dr. Hopper agrees and puts forth a prediction that if the housing market continues to balloon into increasingly more expensive housing, we will see more homelessness in general. Increased homelessness amongst mentally ill persons may in fact be a sign of worsening homelessness overall.

Analyzing deinstitutionalization through the lens of increasing homelessness does a disservice to the aim and goals of deinstitutionalization. Deinstitutionalization was a galvanizing movement in human rights for the mentally and physically ill and disabled. The institutions themselves and the conditions inside were the impetus for this movement; institutions, places where rehabilitation and care were at the heart of their creation, became places where we could hide "undesirables" or "others" from our public view. To many observers, the institutionalized care of mentally ill persons may be a distant

memory. However, institutionalized care continues today, albeit it in other institutions not solely designated for the care of mentally ill persons. Transinstitutionalization, also known as the "institutional circuit," is the phenomenon where mentally ill persons found in jails, prisons, hospitals, bounce from shelter to shelter and back through the circuit again.

In 1990 individuals living with mental or physical disability achieved a catalyzing victory when the Americans with Disabilities Act was adopted. In 1995 the ADA was utilized in the courts to bolster the rights of individuals who were dually diagnosed (individuals suffering from addiction and diagnosed with mental illness for example). In a groundbreaking case *Olmstead v. L. C.,* the Supreme Court ruled that isolating people with disabilities in institutions when there was no need for isolation was a form of discrimination in violation of the Federal Disabilities Act (Greenhouse, 1999). At the heart of the case stood two Georgia women, Lois Curtis and Elaine Wilson, who had mental illness and developmental disabilities and had voluntarily admitted themselves to the psychiatric unit of the State-run Georgia Regional Hospital. After receiving treatment, the mental health professionals at the hospital determined that each woman was ready to be moved to a community-based program. For reasons unknown to the women, they remained confined in the institution for several years after their initial treatment was concluded and deemed successful. In response, the two women filed suit under the Americans with Disabilities Act (ADA) to be released from the hospital.

> On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.
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> The Supreme Court explained that its holding 'reflects two evident judgments.' First, 'institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life.' Second, 'confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment'[2]

[2] Found on the webpage of The United States Department of Justice and Civil Rights Division of the Americans with Disabilities Act. This website contains more information regarding the Olmstead decisions and personal stories of those whom the Department's enforcement of *Olmstead* has aided in release from confinement.

Following this ruling, the Clinton administration required states to evaluate thousands of individuals living in the states' nursing homes, hospitals, and countless other institutions in order to determine if these people could be better served somewhere else in their community. The Federal government enforced this ruling through the provision of Medicaid funding and the enforcement of the Americans with Disabilities Act (Pear, 2000). President Clinton was also responsible for the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which largely reformed the national welfare program. This greatly impacted who can acquire welfare assistance and for how long this assistance would be provided. PRWORA is most widely known for impacting aid provided to families and children, however the act also had wide reaching effects on Supplemental Security Income (SSI), one of the primary means of income for the mentally ill and dually diagnosed (drug or alcohol addiction) homeless and/or low-income individuals.

The political history of policy treatment for the mentally ill, the homeless, and the marginalized is a history wrought with fragmentation of services, programs, and laws. Often policies will contradict or counteract one another. The underlying cause of much of this political and historical context is a social context deeply rooted in stigma.

Social Context

Public stigma influences the manner in which people interact with one another on the street; stigma also affects the way policy makers and officials create policy for the stigmatized cohort. We see this strongly in the form of Nimbyism in planning and development. The definition of stigma used in this context is that of Parcesepe and Cabassa (2013) who define public stigma towards mentally ill individuals as "a set of negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness...it also results in...reduced autonomy and self-efficacy, and segregation;" they indicate that this type of pervasive stigma can lead to negative effects such as: a lack of engagement in mental healthcare and inadequate treatment of the mentally ill and the fact that "individuals with mental illness are more likely to experience housing and employment discrimination and homelessness" (p. 1 Parcesepe and Cabassa, 2013). Their study found that the strength of stigma surrounding the mentally ill was founded in the belief that mentally ill individuals are more dangerous and more likely to commit violent crimes. The stigma surrounding mental illness is pervasive and often leads to the marginalization or increased marginalization of vulnerable populations. The community of the mentally ill has been faced with this stigma before society knew how to diagnose mental illness and

it has continued even after diagnoses have become more regular and specific. Many studies point to this stigmatization of the mentally ill as a driving force in the increasingly visible mentally ill homeless. Furthermore, the homeless (notwithstanding the mentally ill subpopulation) are stigmatized and "othered," compounding the alienation. Despite this entrenched stigma, there is a community of advocates and activists for the mentally ill which has only grown in strength throughout the centuries and works to reverse or mitigate the harmful effects of stigma surrounding the mentally ill.

NIMBY, the acronym for the colloquial phrase "Not in My Backyard," is a form of public response tied to stigma most notably in relation to placement of public developments and capital projects. The phrase connotes the resistance of individuals to support or accept a project by corporations or governmental entities. Motivations behind the intransigence come most often from two perspectives. The first being the individuals who view the project as a detriment to their quality or way of life by way of devaluing their property and causing inconvenience. The second perspective is related to the first, but instead by advocates for social and environmental justice who imply an absence of social conscience by the developer with regards to class, race, disability, or another factor used to classify a marginalized group. The term has come to have a pejorative nature, some would say due to the former perspective coming mainly from middle- upper-class individuals, who will be most vocal, and in those cases the development they opposed ends up in the "backyard" of those who cannot afford to move or formally resist development. NIMBY plays a large role when planning for developments such as shelters, group or adult homes, rehabilitation centers, hospitals, and other centers of care or service where the perceived "undesirables" would be most in need of.

Case Study: New York City: The really good, the okay, and the ugly (not always in that order)

Right to Shelter

Homelessness first became apparent as an abject point of concern in New York City in the 1970s. It was a tumultuous decade in the city's history: street gangs and subway muggings prompted vigilantism and a citywide blackout cloaked the acts of Son of Sam; pornography and illicit drug use found a public home in Times Square; but the 1970s were also a decade for burgeoning human rights movements. It was in the Bowery, where lawyer Robert Hayes found Robert Callahan, a homeless man suffering from alcoholism sleeping on the streets. In 1979, Hayes brought a class action lawsuit in New York State, *Callahan v. Carey*, on the base argument that in New York State there existed the right to shelter. He pointed to Article XVII of the New York State Constitution which declares that "the aid, care

and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions…" Robert Hayes would go on to co-found the Coalition for Homelessness in 1982. In a landmark decision on December 5, 1979 the court issued a temporary injunction requiring the city to provide at least 750 beds and board (Coalition for the Homeless, 1979).

After two years of negotiation, in the summer of 1981, *Callahan v. Carey* was settled as a consent decree, a civil settlement reached by the parties involved without trial but approved by the court. This consent decree set the standards requiring New York City and New York State to provide clean and safe shelter to anyone who meets the need standard for welfare or were homeless "by reason of physical, mental, or social dysfunction" (Coalition for the Homeless website, 2018). It also outlined the minimum shelter standards the City and the State must maintain. Thus, the Legal Right to Shelter in New York was born.

In response to this decree and the ever-growing homeless population, Ed Koch created the modern shelter system in New York City and, in 1985, initiated the use of police to forcibly remove individuals sleeping on the streets into the shelters. Koch was responsible for turning several armories into barracks style dormitories. He used these spaces instead of the previously rented hotel rooms in order to discourage individuals from using the shelter system as a means to gain permanent housing and leave space available to those who truly "needed" the shelter system. David Dinkins ran and won against Koch in 1989. He had a platform that faulted Koch's mayoral practices for not focusing on access to permanent housing. However, in 1991, Dinkins' generosity was seen as a weakness as the shelter population rose (Jeantet, 2014). In 1994, Rudy Giuliani defeated Dinkins and responded with a series of "get-tough" policies which included time limits on shelter stays, work requirements, and narrowed eligibility rules (Jeantet, 2014). Behind all the political headlines, single room occupancy (SRO) homes were steadily declining, estimates by the Supportive Housing Network of New York state that "between 1955 and 1995, the city went from having 200,000 SRO units, to less than 40,000" (Jeantet, 2014). These SRO homes had been the primary form of housing for recently deinstitutionalized individuals.

Despite the ever-growing homeless population and the awareness surrounding homelessness, New York City's level of street homelessness is still much lower than that of other cities, as a percentage of the population. The homeless population of Los Angeles has increased by 32 percent between 2010 and 2016 and is markedly different than the homeless population of New York. This is due in large part to the right to shelter mandated in New York. Most cities provide shelter based upon capacity, New York provides shelter based on need. The ratio of the estimated number of street homeless individuals to the city's total population in New York is 1 in 3,013, and in LA the ratio is 1 in 285 (Palacio and Banks, 2016).

However, the rate at which New York's homeless population rose was 39 percent between 2010 and 2016. The difference in the ratio breakdown is consistent with New York's legal requirement. Due to the right to shelter, the homeless in New York City are not on the streets, but in the shelters.

Olmstead Enforcement - U.S. v. New York

Among the numerous programs in NYC, one program in particular has come under fire from advocates and even attracted legal attention from the Federal government. An Adult Home care facility, also known as an 'article 7 care facility,' is a privately-owned source of long-term residential care. This care is given in an institutional-like setting and includes: room, board, housekeeping, personal care, and supervision. However, they are not licensed to provide any medical care. A person, partnership, not-for-profit Corporation, a public corporation, a non-publicly traded business, or a Limited Liability Company may file a 'Certificate of Need' with the New York Department of Health to operate an Adult Home (NYC Business). Much like the large institutions of the past, Adult Homes were started with intentions of rehabilitating and aiding mentally and physically disabled persons in the transition back into the community; and similarly, to their programmatic cousins (i.e. large institutions), proved ineffective to this end and instead perpetuated an environment of harm. Rumors of outsourcing for unnecessary surgeries, overcrowding and exploitation of the residents of the Adult Homes began appearing in the media as early as 2002 because of the ability for any individual who owns several apartments to open their own Adult Home (Levy, 2002).

In what appears to be a recreation of past events, advocates on behalf of the occupants of the Adult Homes filed suit. The United States Department of Justice enjoined filing suit against Governor Paterson and several Department heads including the Commissioner of the New York State Office of Mental Health (ADA.gov). In the following year the case was filed suit by the United States government against the State of New York, citing a violation of the *Olmstead* decision, *U.S. v. New York*. Governor Cuomo agreed to settle with the Federal government in 2013 to give approximately 4,000 individuals living in institutional style Adult Homes the opportunity to move into supported housing in the community, of which 2,000 additional units were to be created. The settlement was renegotiated in 2017 after Judge Garaufis (the presiding Judge through the course of litigation) evaluated the City and State progress in the movement of these 4,000 individuals. It was found that fewer than 500 individuals had in fact been moved into Supported Housing (Santora, 2017). Judge Garaufis was suspicious that the City and State were working with the Adult Home industry to undermine the court's ruling in order to avoid the increased costs associated with appropriately resourcing group homes like the Adult Home

industry. In May 2017, the Second Amended Settlement Agreement was signed and approved by the Court. This Second Amended Settlement is highly specific, presumably to preempt any attempt by the City or the State to determine a way around the ruling.

Supported Housing

In response to deinstitutionalization, innovators developed community-based methods for providing not only care but also housing. Created in the 1970s by two Franciscan priests, supportive housing is a form of affordable housing that integrates on-site support services such as medical care, case management, counseling and psychological services, assistance in gaining access to and understanding government benefits, exercise and/or recovery-oriented and vocational classes. There are two primary types of supportive housing: single-site (or congregate) and scattered-site. Congregate supportive housing is located in a designated building in which each family or individual has a private living quarters but may share a kitchen or common room. Scatter-site supportive housing are units spread throughout a neighborhood or community and have been designated for a specific population. Supportive housing is not designed to be transitional housing, it is permanent and provides housing for families or individuals coming from a period of homelessness, incarceration, or hospitalization with integrated, quality housing and standard lease and rental assistance.[3] As a development strategy, supportive housing utilizes the practice seen in Urban Renewal of taking blighted structures and rehabilitating the building. In the case of supportive housing, the buildings were then transformed into permanent housing for the elderly, low-income, and/or mentally ill. Supportive housing as a form of subsidized housing and its effect on its target population has been studied and proven effective. However, I was unable to find a study which analyzes supportive housing as a way to highlight the benefits to the community in which it exists. Many of the supportive housing programs in the City are designed to be "good neighbors," so as to both mitigate Nimbyism and foster social cohesion throughout the community as a whole. There are currently multiple organizations[4] and projects in New York whose mission is to promote and aid individuals in acquiring supportive housing.

New York City was the first city to employ the Housing First model. This is a stark contrast to the previous method of care, the Continuum of Care previously mentioned. The Housing First model is simple: it places housing as the priority before prioritizing sobriety and/or being stable and on

[3] According to the NYC Health website, Housing Services (Supportive Housing) information page. Housing Services Supportive Housing. Accessed March 16, 2018. https://www1.nyc.gov/site/doh/health/health-topics/housing-services-supportive-housing.page.
[4] Two of which are represented in the Oral History portion of the paper.

medication; in tandem to proving housing, Housing First programs provide supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. Created by Sam Tsemberis in 1992, Pathways to Housing was founded on the principles of Housing First and believes that "housing is a basic human right," and is "designed to address the needs of consumers from the consumers' perspective...encourag[ing] consumers to define their own needs and goals and, if the consumer so wishes, immediately provides an apartment of the consumers' own without any prerequisites for psychiatric treatment or sobriety" (p. 651 Tsemberis et al., 2004). This model also values the importance of supportive housing as a tool for ending chronic homelessness and integrating health services. This integration of services and development is gradually being recognized not only by academics and innovators like Tsemberis, but also by politicians as an effective tool not only in terms of providing stable housing and services, but also as a cost-effective solution compared to the institutional circuit.

New York City Today

Mayor Bloomberg came into office in 2001, two decades after deinstitutionalization, when homelessness was at a record levels throughout New York City, with 33,840 people in the shelter system as of June 2002 (Steinhauer, 2002). In response, the Bloomberg administration planned to increase the number of government subsidies for apartments by distributing more Section 8 vouchers to the homeless. In a departure from the goals of the Giuliani administration, Mayor Bloomberg's plan called for more outreach to those individuals living on the streets who ardently avoid shelters, such as the severely mentally ill. In 2013, there were more than 52,000 homeless people residing in the municipal shelter system (Markee, 2013). In the final year of the Bloomberg administration the housing subsidy program was ended, and the 2008 Recession hit, and homelessness rates began to rise again.

This was the situation Mayor de Blasio faced when he took office in 2014. In a report (2016) titled "Turning the Tide on Homelessness: in New York City," the de Blasio administration outlined a plan that integrates agencies such as DHS, DCP, DHMH, etc. to engage in a multi-pronged approach. The first prong focuses on housing affordability and ending illegal evictions. The second prong deals with enacting operational reforms to improve shelters and help neighborhoods better serve people. The third and final prong reimagines the shelter system in ways which will remove people from cluster apartments, cut the total number of shelter facilities by approximately 45 percent and keep homeless individuals as close to their own neighborhoods as possible. This plan hopes to greatly reduce homelessness and while it recognizes that there are no "silver bullets" which will effectively and easily

end homelessness, it hopes to achieve strides in housing for as many individuals as possible. It is innovative, as the de Blasio administration recognizes that in order to reach their goal, they require the expertise, resources, and cooperation of many departments.

Prior to the plan in November 2015, Mayor de Blasio committed to increase supportive housing units throughout the city by enacting NYC 15/15: an additional 15,000 units over the next 15 years. The mayor's Supportive Housing Task Force team was created to advise the city on implementing the plan. The task force was diverse, with 28 experts from the public, private, and nonprofit sectors[5] however, there was no representative from the City Planning Commission or the Department of City Planning. The recommendations from the Task Force can be found in the plan and include: targeting units to adults, families, and youths, allowing additional professionals to complete mental health evaluations to expedite the application process (thereby increasing access), using evidence-based practices, and emphasizing staff development. The development of these 15,000 units are in addition to and separate from the units of supportive housing the Courts have ordered the City and State to develop (Palacio and Banks, 2016).

In addition to the de Blasio administration's vocal support for supportive housing and expounding the need for more shelters, more shelters are being and have been developed. A New York Times article[6] documented the location of shelters in the City and compared the concentration of shelters to the concentration of the origins of homelessness. The article discovered that many individuals were becoming homeless in one borough or neighborhood and were then being sheltered in another, often several miles away. The article was written only a year after Mayor de Blasio's plan was released, and though it highlights his failings in achieving the plan, such as the placement of shelters in relation to those entering homelessness. The article (2016) displayed maps highlighting the disparity of shelter availability in communities with greater risk of entrance into homelessness. However, this also better displays the failings of past administrators in their efforts to match the Right to Shelter in the wake of deinstitutionalization and the lack of affordable housing.

The de Blasio administration recognizes the need to imbue housing with supportive services. He has even taken to implementing health and education services in the shelter systems for those individuals in need. The challenge for New York City and New York State is in the enforcement of the Constitution to ensure a legal right to shelter. Data sharing is another area where New York is both

[5] Two of which, Brenda Rosen and Kristin Miller, are represented in the Oral Histories.

[6] *New Homeless Shelters Are Coming to New York City: Which Neighborhoods Are Likely to Get Them?* By Nikita Stewart, Ford Fessenden, and Tim Wallace. Published on July 22, 2017. De Blasio's "Turning the Tide on Homelessness" was released in February 2016.

innovative and stalwart; programs like HOME-STAT increase data availability. However, if the data cannot be shared more readily and quickly across institutions people will continue to be lost in the institutional circuit and perhaps be hindered from finding housing. It remains to be seen whether or not the de Blasio administration will follow-through on their promises for improvements in the provision of services and access to permanent housing for the homeless, in particular those living with mental illness who no longer have access to the institutions since deinstitutionalization.

Oral Histories/Methods and Data

The use of oral history has long been contentious in scholarly works, not because it is seen as un-useful, but because it has been difficult to define and is viewed as primarily anecdotal at best. For the purpose of this study, my research will utilize the definition put forth by Valerie Raleigh Yow: "oral history is the recording of personal testimony delivered in oral form." She goes on to describe it as a "life history" of the interviewee (p. 3-4 Yow, 2005). It is the method of recording and preserving oral testimony. Recordings can occur in any format, though historically, histories have been recorded through the use of audio mechanisms (Yow, 2005). The importance of the oral history is in this nature of the interviewee dominating the conversation; it offers a greater opportunity for an unbiased response (unbiased by the interviewer, the interviewee will bring their own personal perspective). An interview, even an in-depth interview, can be interpreted as a guided discussion, where the interviewer posits questions which may lead an interviewee to look more closely at one area than another based on the interviewer's own interests. For this research, the inherent evocative nature of an oral history is what is pertinent. In an oral history collection, the interviewer often leads the conversation back to the main idea but asks far fewer questions of the interviewee. Oral histories are most useful in research and literature aligned with advocacy goals. I am using oral histories as a method to elicit individuals' personal perceptions of this nationally shared experience because "oral histories provide a valuable source of knowledge about past events while offering new, interpretive perspectives on the present" (p. 905 Trujillo et al., 2014).

All of the individuals, with the exception of Becky MaGuire who worked in Florida, currently work in New York City, as this is the case study site. However, I wanted to include a perspective on deinstitutionalization that was outside of New York, as it was a national level policy change. Using a snowball sampling approach (meaning I asked each interviewee if they had any participant suggestions based upon what they knew of my interests and the field), I collected histories from individuals who had all worked or work in the Continuum of Care or supportive housing programs and who had specifically

been suggested to me based upon their work's intersection with mental health. The significance of gender in the field was not a driving force in choosing participants, however each interviewee is a woman.

Each oral history was recorded in one hour-long session and transcribed at a later date. Two of the interviews were conducted in-person and two were conducted via phone call. Using a semi-structured interview guide I began each interview with a brief description of my interests in mental illness and homelessness. I explained my research process as I traveled from deinstitutionalization into modern forms of housing and care for the mentally ill, specifically the mentally ill homeless. I encouraged each interviewee to share their own personal journey in their work and any interesting anecdote they might have collected over the years. I asked each woman to tell me her story, the overview of their professional experiences of each interviewee is recounted first followed by a section aggregating their insights on the subject matter.

Becky MaGuire[7]

It is apropos that I should start my interviews with Ms. Maguire. Her story highlights the great complexity faced by cities and states in responding to deinstitutionalization; and that is where I began my own literary research, at the start of deinstitutionalization. Becky Maguire has been retired for four years, and to label her career with one title would be a disservice. She worked in various sectors and areas throughout the Continuum of Care, from case worker, to nursing, and administrative staff roles. It was in one of these positions where she met my aunt, who provided me with Ms. MaGuire's contact information. Her story also exemplifies the intricacies of the system and the necessity for what she called "institutional knowledge." She started her storied career as a teacher after getting her undergraduate degree in history education. She went back to her hometown where she taught during the day. Around this same time there had been a large deinstitutionalization effort and was enlisted to help run a local group home:

> The home was to be populated with three women from the community who were mentally retarded [sic] and three women from the deinstitutionalization effort in the local institutions that had been there for years and years and years. That's actually how I started. The lack of success in that project is what led me to go back and get my [master's in vocational rehabilitation in counseling].

[7] For full text see appendix pgs. 46-53

After attaining her master's degree from Florida State University, Ms. MaGuire went to Miami for a year and worked at a workshop that housed about 100 individuals from the community and the local institutions. She was then offered a position 50 miles South of Tallahassee as the Executive Director for the Association for Retarded Citizens. She stayed in this position for another year before going to work for the State of Florida. While working for the state she also did work in vocational rehabilitation as a supervisor for the aging and adult programs run by the state. Then, she changed jobs again; "of all the things I had done, they ended up offering me a job in children's mental health. That was where I actually began my mental health career."

All kinds of interesting things happened with children's mental health at that time. According to Ms. MaGuire, the State of Florida had over 100 children placed in "residential settings," most in state institutions but several in programs that were more akin to boarding or reformatory schools, outside the state. The legislature had decided that they were a population of "gone and forgotten" children and they wanted to make an effort to bring them all home. The State of Florida issued an edict that all of these children were all to be brought back to Florida. Becky MaGuire ended up being one of the people who went out to all of the localities where the children had been placed and make a decision and then broker what those kids needed back in the state of Florida.

In her quest to bring the 100 kids back to Florida, Ms. MaGuire came up against push back from the institutions she would approach. She postulates that they were afraid of losing patients and consequently money, rather than genuine concern for the children's wellbeing. Their opinion was that Ms. MaGuire was not a medical professional and was therefore taking the children against medical advice. At the same time, the state of Florida had an Educational Leave program: because the state was short on nurses, the program effectively paid an individual for the two years they were getting their nursing degree, but then that person would in turn work for the state upon graduation. Ms. MaGuire decided to take this educational opportunity, but in order to qualify, she had to be an employee at an institution. She then took on the role of "gatekeeper" for the state institutions in North Florida, which involved her representing the State of Florida in the Baker Act Hearings. A Baker Act hearing is an involuntary admission of an individual who is mentally ill. According to Ms. MaGuire, with the signature or a physician and or law officer an individual can be involuntarily admitted for up to 72 hours. After these 72 hours, a team of mental health professionals evaluate whether or not that individual should be retained or if a different course of programming or resources would better suit his/her needs. Her role as gatekeeper was to prevent judges from ordering mass people into the state mental hospitals. She was then able to start and complete her nursing degree and became a nurse for one of these large

institutions working primarily in the Alzheimer's units but did also spend significant time in the wards in which deinstitutionalized patients were housed.

Becky MaGuire's career take-aways were ingrained in personal relationships and engagements. She spoke frequently about the loss of institutional knowledge which she defines as the knowledges developed by individuals doing the work, learning the lessons, and passing this along to the next generation of administrators, professionals, and/or volunteers at all levels. This is established in community cooperation, engagement, and understanding. She believes that by creating an engaged community built on understanding we can reduce stigma. Her final lesson is in enhancing overall care and well-being through one-to-one care, in her experience the most successful programs for the deinstitutionalized and mentally ill were not the most "glitzy" or highly funded, they were run by people who genuinely cared for and about the individuals they were there to serve.

Brenda Rosen[8]

On a chilly March afternoon, I walked briskly to the office of Brenda Rosen who is the President and CEO of Breaking Ground. Founded under the title Common Ground, Breaking Ground is a supportive housing program in New York City. Their Times Square location remains the largest supportive residence in the country and they have provided thousands of individuals with a chance to find a permanent home. Ms. Rosen shares her experience:

> When I started out, I initially thought I wanted to be a social worker. I knew I wanted to impact change for the better and after doing an externship for the city council a long time ago and working with social workers, I realized that I wanted to take a different path. So, I ended up going to law school and focusing more on public interest type of law classes…

After obtaining her degree, Ms. Rosen started working for the Department of Homeless Services (DHS) as an attorney. DHS was a young organization at this time and had previously been a part of the Human Resources Administration (HRA,) but then broke away into its own agency. It was small and new, which meant that Ms. Rosen was given a lot of opportunities that would not otherwise have been available. Now DHS is a large agency and has grown concurrently with the issue of homelessness and has since merged back with HRA. Ms. Rosen ran the central intake center in the South Bronx for homeless families. She was tasked with developing a legal program to review the decision timelines made in regard to whether people were entitled to shelter or not. She was also asked to run the operations, which consisted of managing about 400 staff members. In this position Ms. Rosen learned

[8] For full text see appendix pgs. 53-58

the legal, physical, emotional, and fiscal implications of homelessness, as well as the unique challenges that come from being homeless.

In 1999, Brenda Rosen received a call from the founder of Breaking Ground to open up the second supportive housing residence for the organization. Breaking Ground allowed Ms. Rosen to see homelessness and help homeless people on the other side of intake; providing them with stable housing and resources that support the goal of never returning to homelessness. In 2011, the president and founder left the organization, and Ms. Rosen assumed the executive position she presently holds.

Brenda Rosen spoke extensively and in great detail about her career with Breaking Ground and Breaking Ground's work and mission as a successful model for supportive housing and a tool for aiding the mentally ill homeless. She discussed the challenges she has seen homeless individuals and families face, in particular she discussed the challenges that accompany housing mentally ill homeless. Supportive housing developments like the ones created by Breaking Ground are indicative to the gap in service and housing provisions that were left in the wake of deinstitutionalization. Breaking Ground works to be a "good neighbor" and in so doing, have been able to overcome stigma and reduce the effects of NIMBY on their present and future developments. As an organization they work to create community buy-in through integrative community shared spaces.

Kristin Miller[9]

Kristin Miller, despite her extremely packed schedule, was able to meet with me almost immediately after I reached out to her. I had received her name from Dr. Hopper in a list of names he advised me to reach out to. Ms. Miller is the director of the metro team for the Corporation for Supportive Housing (CSH), an organization which was founded in 1991 and whose mission is "to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources, and build healthy communities." As Ms. Miller briefly explains, CSH is an intermediary organization that acts as the link between programs, organizations, developers, and models in housing and the policy and decision makers who can help get programs off the ground. CSH also works to reform and improve government systems, provide capital funding to build supportive housing buildings, educate and empower industry players, and lead and expand the supportive housing industry. Ms. Miller has been with CSH for nearly 13 years and started as a consultant. She has been in the position she holds now for five years. She says how she got here was a "windy road..."

[9] For full text see appendix pgs. 58-67

> I have a bachelor's degree in social work from Augsburg College in Minneapolis. After college I got a fellowship in NYC, it was a 10-month fellowship; the NYC urban fellows program...I ended up working at the NYC HRA, let's see if I can remember my title, I was the Special Assistant to the assistant commissioner in special services for adults within the Human Resources Administration. That fellowship threw me into Mayor Dinkins' "5-year plan to end and assist homeless adults" ...I was thrown into the politics of homelessness on my first day in the job.

Ms. Miller was working in the late 80s and early 90s when the crack epidemic changed the face of homelessness in New York City and created a new profile of individuals living in a state of homelessness and actively using drugs. She also noted that homeless families were also a growing profile. This was also when the Callahan Consent Decree (otherwise known as the Right to Shelter) was enacted. In response to this, Mayor Koch, housed many of these individuals in the armories of the past. These huge armories housed around 1200 people (like the Fort Washington example provided by Ms. Miller) on the armory drill floor in cots and with security and it was not a good situation for anyone, clients or staff. When Kristin Miller was hired, the department was trying to create an alternative, a kind of "boutique shelter" that provided social services, more than just "three hots and a cot." This system acknowledged that people had issues that needed to be handled and addressed, in addition to them needing housing. Ms. Miller's job was to promote these "boutique shelters" that were part of Koch's 5-year plan. In this process, Ms. Miller was tasked with finding sites for these shelters to be located in, which caused her to bump into NIMBYism which she found increased insecurities amongst the elected officials. In the end, she found that few of the shelter programs were completed with the original intentions.

After her fellowship ended, Ms. Miller stayed with the mayor's office, lobbying the city council on general welfare issues. When the incumbent party won, she was let go and went to work for a community development corporation which dealt more with housing. In this corporation she learned a new model of housing which offered "cradle to grave" services and affordable housing. Following this experience, Ms. Miller went back to city government as the assistant to the Commissioner of Homeless Services. She worked under Dinkins in city legislative affairs and drafted and passed legislation that separated the homeless services function from the HRA.

Ms. Miller then went to work for a supportive housing provider in the development department doing program planning and program design. Her past experience gave her insight into understanding how the capital planning and financing functioned in creating supportive housing. The position at this supportive housing provider embedded Ms. Miller in the world of supportive housing.

Kristin Miller spent the most time of any the interviewees working for and with the local government, which has given her unique insight into the political and legal realm and the challenges that right to shelter and NIMBY have caused. She also discussed the intersection between planning and resourcing for housing the mentally ill homeless and the future implications. Her strongest belief is that housing alone is not enough, she explains that this is more than just services like psychiatry and healthcare but also job training and a means to an economically stable end for the mentally ill. In a sentiment that I heard echoed throughout she said, "we can't build our way out of this." There will always be homelessness, but the goal is to have the smallest amount of people entering into homelessness with the smallest percentage remaining homeless.

Jessica Katz[10]

Jessica Katz is the executive director of Citizens Housing Planning Council (CHPC) of New York City. She was recommended to me by Kristin Miller who thought Ms. Katz might be able to give me a planning perspective on housing the mentally ill homeless. I was excited by the opportunity to finally speak with a planner, and not just a planner working in the housing field but a planner who spent much of her career working at the intersection of planning and mental healthcare. Unfortunately, our interview started off in a discordant manner as the application I had been using to record the interviews was malfunctioning. However, Ms. Katz was agreeable and understanding despite this hiccup. I asked her, as I had with the other interviewees, to tell me her story.

> My first job out of college was at a nonprofit mental health agency in Massachusetts doing supportive housing development. It was kind of perfect for me, I've always been at the intersection of social work and urban planning. But frankly I would have made a terrible social worker, so it was nice to find a niche of supportive housing development where I could do the work I thought was important, but also play to my professional strength. I did that for several years then went back to get an urban planning degree from MIT.

She then went to work for the City of New York for the Housing and Preservation Department (HPD) for 12 years, running the supportive housing program; loaning capital to not-for-profits to develop supportive housing throughout the five boroughs. HPD had approximately 200 million dollars a year and maintained a pipeline of up to 1000 units of supportive housing each year that was loaned out to complete the physical housing structures. Ms. Katz described how HPD doesn't build its own housing but loans funds to nonprofit and private developers and then retains intensive oversight over these loans. She then left city government to take her current position.

[10] For full text see appendix pgs. 67-73

> The housing and planning intervention for homelessness and behavioral health issues has been the main mission of my career.

Despite no longer working solely on homelessness and behavioral health, her new career with CHPC does contain similar overlap. Since 1937 CHPC's mission has been "to develop and advance practical public policies to support the housing stock of the city by better understanding New York's most pressing housing and neighborhood needs." The CHPC is a not-for-profit organization that brings together 90 professionals who work in a variety of industries all involved in housing development and management. As a community of professionals and expert research staff, they conduct research and analyze the findings to assist decision-makers inside and outside government to draft realistic steps in changing the housing stock and the neighborhoods of New York City.

> The CHPC is a think tank in New York that promotes practical housing policies. We like to say that our client is the housing stock of the City of New York and that our goal is to advance practical housing policy and also to ensure that the housing stock of the City meets the needs of the population of the City.

Jessica Katz is not the only planner working at the intersection of planning and behavioral health issues however she was the only planner I was fortunate enough to speak with. The interview with Ms. Katz truly highlights the role of the planner and the versatility a planner must possess. She creatively uses her skills as a planner to not only advocate for a group of individuals who are not able to represent themselves but to also meet the needs of the community at large and invite civic engagement in the planning process. In this process she discussed learning how to overcome stigma and NIMBY to help site supportive housing projects. Ms. Katz also spent time discussing the challenges involved with creating housing for the mentally ill and recently deinstitutionalized. Her belief is that there is a causal link between deinstitutionalization and an increase in the mentally ill homeless and to disregard this would be a disservice to those individuals who were left without housing and care after deinstitutionalization.

Oral History Themes

Throughout the collection of these oral histories several motifs were made apparent. Even though each woman experienced them in her own way, the overarching themes are strikingly similar. Each interviewee sited: community reaction and interaction (stigma, NIMBY, community buy-in, etc.), the challenges of and innovations in procuring resources for mentally ill individuals, the intersection with traditional planning and the role of planning, and future implications of and potential solutions to housing mentally ill individuals and homelessness in general, throughout her interview.

Community Reaction and Interaction

The physical location of supportive housing developments, like shelters can insight a visceral reaction in the host community. Jessica Katz worked specifically in this arena, directly dealing with and managing community expectations and the ensuing stigma:

> siting supportive housing has become, over the years, sort of an expertise of mine and battling against the fear and the uncertainty and the NIMBYism frankly, that happens when you try to site supportive housing project in someone's neighborhood and figuring out how to get past that and create some consensus.

She notes that everything from the manner in which you enter the room to clothes you wear can impact a community meeting. She recognizes that as a government official you are not always going to be the favorite in the room and are often, instead the conduit to which negative emotion can flow. Ms. Katz takes this position very seriously and suggests planners allow the public to state their frustrations, as this can be cathartic and lead to more productive and honest conversations about the fear the public may have regarding future tenants of shelters or supportive housing developments.

This fear of the future tenants was echoed by Kristin Miller and Brenda Rosen. Ms. Miller discusses how NIMBYism is the impetus for her appeal for further research on the impacts and effects of supportive housing programs:

> I think that the beauty of supportive housing is that particularly in our urban environment, in our dense environment, it's very easy for somebody to understand that we build [mixed] apartment buildings. And NYC has been a lead in mixing, what we call "special needs units," the supportive housing units, with affordable units. So, it's "normalizing" life for all of its residents. Any apartment building in NYC has people with lots of different backgrounds and lots of different things going on in their life. So that's what we're doing. Therefore, when we talk about the development of supportive housing and Jane Q. Public says, "oh we don't want a shelter here." We have to say, "well it's actually not a shelter it's permanent affordable housing." But still there's this fear factor of 'those people' moving into 'my block.'
>
> What we know is that [supportive housing] improves the real estate values, it brings stability to the neighborhood, the buildings are beautiful, they're run by mission driven organizations who care about the community, the fears of "oh you're going to serve women in this building? Oh well prostitution and I don't want the johns. And the drug dealing" and all of this stuff comes out. Outside of NYC more so than in the city is "well family housing? It's going to overburden my schools", so they come up with every reason not to [have supportive housing]. We are looking for much more research, documentation, evaluation, of the value of supportive housing in communities because we know it absolutely improves things.

Brenda Rosen explains why supportive housing developments, like the ones completed by Breaking Ground are and have been assets to the communities in which they are located. She describes the

methods and strategies take by Breaking Ground to be a "good neighbor" and more fully integrate into the whole community, not just the community of residents on the grounds.

> We are looking to build in those neighborhoods to provide, not only buildings, but to be able to help improve communities in a much more holistic fashion. So, with every building that we build, we have something that is [for the community]. The buildings that we build are built with a focus on sustainable design… Most of our buildings people walk by every single day and have absolutely no idea that that's who we're serving inside… We always want to have another type of give back to the community, so it may be a retail space, a community facility space; essentially this means we're able to rent it out at a very low cost. We want to bring in a strong not for profit partner that is going to be helpful to the community but doesn't have the money to pay the normal retail rents.

Kristin Miller also references Breaking Ground and similar supportive housing programs as "YIMBY" catalysts. The hold the potential for communities to say "yes in my backyard" for developments of supportive housing.

Challenges and Innovations in Resource Procurement

The primary challenge in resource procurement occurs on an individual level. Individuals with serious mental illness often require specific aid, care, services, medications, surgeries, housing typologies etc. These needs are especially visible in a post-deinstitutionalized world, where the onus is on local entities to acquire the necessary resourcing mechanisms. Ms. MaGuire worked most closely with the healthcare field throughout deinstitutionalization and specifically in the arena of resource procurement, she most frequently witnessed and interacted with individuals who were left lacking after they were required to move out of the institutions:

> Tallahassee doesn't have the greatest public transportation. So, there were so many challenges in moving people and I can remember there was one guy who had been an accountant and trying to get him back out of the hospital, ultimately, I convinced the hospital administrator to buy him a one-way plane ticket to Vegas. And we sent him there and he went door to door with his accounting credentials and eventually got himself a job. We had a lot of creative solutions that went on during that period of deinstitutionalization.

In connection to this individual access to resources, the timeline in which a mentally ill person gains access to adequate resources was also a challenge. Becky MaGuire shared a story about a woman she helped in her first job, as a teacher at a group home, who had a cleft lip and trouble with speech. She was told that they would correct the palette issue once the woman had been stably employed, however Ms. MaGuire ardently disagreed referencing this woman's complications speaking as an inhibitor to stable employment. This sentiment, of access to suitable resources prior to successful

rehabilitation, was echoed by both Ms. Rosen and Ms. Miller. Brenda Rosen explains that it is nearly impossible for an individual to be clean and properly medicated if he/she does not have a roof over his/her head, she says that Breaking Ground has a saying "housing is healthcare."

> First off, if you have undiagnosed mental illness, you don't even know that medication can help you but let's just pretend for a second that you do know and not many people have, where they're sleeping, a refrigerator where they can then put their medication there are so many daily things that stop somebody from being able to be successful without a roof, and a secure place to sleep at night.

Many medications for schizophrenia and other serious mental illnesses, not to mention individuals who are dually diagnosed with HIV/AIDS or drug addiction, require refrigeration to be effective. Ms. Rosen says requiring individuals to meet this bar for entrance into stable and permanent housing is impossible, "first, let's get you where you're not spending all of your energy trying to figure out how you're going to make it to the next day."

Brenda Rosen also explains the financial burden for the construction of supportive housing units stating that this is why there are not enough Breaking Ground developments. She points to land tenure as a blockade in the development, and when she is able to find affordable land it is often too far removed from other services a resident may need, such as public transportation.

> I've been asked why don't you do 2, 3, 4, 5, buildings? And the answer is that we don't have, we're a not for profit, we don't have the funding, to be able to go and put down deposits on 5 different pieces of land. We don't have the balance sheet to go to a bank and say we want to build a 60 million dollar building and we want you to lend us the money, five times. We can handle basically one at a time. If tomorrow land was more affordable and we were given the resources such that we could do 5 buildings a year, we would be doing five buildings a year and we wouldn't think twice about it.

Role of Planning

The primary role of planning mentioned by all four individuals was the role of locating and allocating appropriate resources in the community. At the federal level, the Department of Housing and Urban Development provides access to funding and financial aid. Planners often act as an intermediary or for an intermediary organization, such as the role Jessica Katz played when working for HPD and Kristin Miller with CSH.

Jessica Katz, as a planner working at the intersection of behavioral health issues and housing offered the greatest insight to the role of planning. Her perspective is particularly interesting when you consider the amount of NIMBYism and stigma faced by the target population.

> On the one hand having a planner's lens about how to get community buy-in, figuring out who the stakeholders are, and some of the things you learn in planning school around building community support and building consensus have been very useful to me working in a field where I need that to effectively build supportive housing on the ground. On the other hand, I think a planner's lens sometimes tends to be about figuring out the right way to ask the community what they want, and that is somewhat counter to what has been important in my career of building supportive housing because at times no one wants supportive housing, but no one wants homelessness either. Sometimes my job has been to do my work despite what the community wants or convince the community otherwise. Whereas a typical planner's lens is asking the community what they want and try to do that thing. But when it comes to homelessness and mental health and substance abuse it's a little more complicated than that.

Increasing the scope of zoning is also an area in which planning has found and can find further footing. Brenda Rosen explained how City Planning is often on the side of Breaking Ground especially after she and her colleagues explain how such a development might be an asset to the community:

> We can build in residential zones. We often look though to up zone. We go to a piece of land that would only accommodate 40 units of housing we go into the City Planning Commission and we argue that we should be able to up zone and build 150 units of housing. So, we do that. And on occasion we will find property in a manufacturing zone and then go through the city process to get that changed to a residential zoning. We can't build everywhere, but we have had a lot of success in getting support to get waivers or change the zoning for a particular area… If you go into a neighborhood where originally, it's zoned for a few dozen units and you want to up zone for 100 then how is that going to impact all of the neighboring services, if it's families are you going to have enough seats in school, is it going to be too much of a drain on public transportation because there's more people. So, our experience is that we have to present to Housing and Preservation and we have to present to city planning what the vision is for what we plan to do and how we're going to address all the other ancillary impacts that our development will have and that if we can do that and it's reasonable they're very reasonable back.

Lessons and Future Implications

Becky MaGuire relayed a story that highlights a lesson reiterated in the other interviews a lesson that shows how making one-to-one connection with an individual can mean more than even the most expensive programs. In her work observing children who had been outsourced by Florida to other institutions she witnessed on program which was working to be more mindful of patients and service provision:

> If somebody recognized that a child had a particular issue that day they would take a string and tie the string to the wrist of the child that had the issue and take the other end of the string and tie it to a staff person. Basically, the message was, "I know you're struggling today, I know you're having a problem, I'm only as far away as the string because I'm the one who can make the difference for you today." And it was just amazing

> to me to see what kind of a difference that made. And as we go on and learn what we learn, particularly about kids and or adults who have mental health issues, acting out in many cases simply means, "I just want a little more attention. I don't know what's happening to me, I don't understand really well and if you can help me as I go through whatever it is I'm going through then that's going to help me a little bit more."

A similar lesson was provided by Jessica Katz on what she calls farming relationships, "people want to know that they can trust you and the only way to do that is to keep showing up" - farming relationships is interesting because it applies on both ends of the project; on the supportive housing side they build relationships with the clients who are looking for housing and on the planning side she's building relationships with the community.

> I think that can be a hard place to work from, but I think for me at least it's been incredibly rewarding to make sure that my job is standing up for people who don't get a chance to participate in civic conversation. I think generally speaking if you're going to do housing policy, it's very hard for me to declare a housing policy victory when there's 1000 people with no place to live in this town.

Ms. MaGuire also presented her experience on the failings of institutional knowledge, a factor not outright stated by the other participants but alluded to, especially by Ms. Miller who worked most closely with government for the longest period of time (out of the remaining three interviewees). Ms. MaGuire said:

> Many, many times I took the same problems with me from one desk to the next. I would say today the same problems are still there that have been there. I blame that on the fact that you have so many of the people down lower in the system who continue to try to solve the same problems but the administration changes so often that it's a matter of trying to bring those people up to speed and you lose progress. They have different ideas of how things ought to be done. They continued to try to do things that had been tried and failed prior. We are losing the institutional knowledge.

Ms. Miller references this issue when discussing the degree to which information is not shared amongst branches or departments of the government:

> when you have multiple agencies together you can have the right housing options for people. Where we encourage communities to begin is to find the most frequent utilizers of the most systems. When the Department of Corrections, Department of Homeless Services, Child Welfare, and hospitals start to look at their frequent utilizers you're going to find that there's about 500 people in common (I'm making up numbers here). Those individuals and families are experiencing poor outcomes because each siloed agency can't hold onto the person long enough to meet their goals to achieve the outcomes they hope for. They can't deliver the services the way they intend because they (the clients) keep going. It's a revolving door. The families, the individuals, certainly aren't getting the outcomes that they want because they keep moving from one system to the next.

According to Ms. Miller this is not from lack of effort. The Manhattan Outreach Consortium, a conglomeration of all the outreach providers in Manhattan "created a database in 2007 that identifies people, puts in case management important info, and matches them to housing. They can get somebody into housing in two weeks, but if you go through the traditional, typical way it can take two to three months." Her answer to why this is happening is complicated, she believes it is a number of things including politics, money, and power.

All of the women agree that an increase in the affordable housing stock, regardless of attached services will aid in reducing the homelessness problem. However, they also agree that we cannot build our way out of this. It is a combination of policy reform and cultural reform in association with development of affordable housing and services. They also agree that cross-systems, multi-sectoral approaches will be necessary in the future to maintain institutional knowledge and propagate success.

Literature Review & Comparative Analysis

In my research I analyzed the intersection of three fields of literature and how this literature compares to the real-life experiences of individuals who have worked or are working in the aforementioned fields: research on deinstitutionalization and homelessness, homelessness and mental illness, and housing programs and efficacy of these programs on their target population. The final grouping of literature is expansive and includes everything from federal policy such as the Section 8 certificate program and SSI/SSDI to supportive housing programs. As there is a paucity of literature from the planning field directly, this paper has pulled together an assemblage of readings from various fields relating to mental illness, public policy and subsidies, and mental health service provision. There is an extensive body of text on the stigma and public perceptions associated with mentally ill individuals. This theme connects several of the studies and articles as well and was present in all of the interviews. It appears to preclude many of the studies or is an active element in their statistical analysis and as such will be discussed first.

Stigma Revisited

Thomas E. McCollough, a professor of religion at Duke University, puts the onus on the public stating, "the question of dangerousness entails a moral judgement of blameworthiness on the part of the community and is an issue of social policy" (p. 256 McCollough, 1974). McCollough's paper "Mental Illness and Public Policy" marks three areas of interest related to the moral rights of the mentally ill: policy imperatives, the right to treatment, and community acceptance. The third interest is based in the

idea that "community attitudes, the 'set of values,' 'those permanent and pervasive feelings of society' that underlie the constitutional rights" for minorities and marginalized groups are the responsibility of legislative bodies and policymakers (p. 257 McCollough, 1974). Furthermore, "relegating the 'sick' to institutions as a means of excluding them from our society" is morally corrupt (p. 257 McCollough, 1974). McCollough was a champion of the community-based mental healthcare system as a means for servicing deinstitutionalized individuals. As with the condition of mentally ill persons being seen as dangerous and violent, McCollough believes, "the degradation and despair engendered by the neglect of the mentally ill is characteristic of America's subculture of misery," due to the fact that America's affluent "coexist with an invisible land of poverty, deprivation, illness, and despair" (p. 251 McCollough, 1974). Despite being published more than three decades prior to Parcesepe and Cabassa's study on stigma, it is clear that there was and has long been a tradition of stigma surrounding individuals with mental illness.

Chris Philo discusses this aspect in detail in his study *Same, Other, NIMBY and an Asylum by the Sea* which revisits his past work on NIMBYism and a community which fights the development of an "insane asylum" (Philo, 2014). He echoes the remarks of the previous analysts with respect to how "an enduring feature has been the question about how spaces 'reserved for insanity' (paraphrasing Foucault 1965, 251) have been regarded by their neighbours, specifically the local populations living next door, in the next street or the same settlement" and how these neighbors have seen these spaces negatively (p. 216 Philo, 2014). Kristin Miller and Brenda Rosen discuss NIMBYism in great detail as it relates to developing supportive housing buildings. Ms. Miller highlights an example in her career: "When we talk about the development of supportive housing and Jane Q. Public says, 'Oh we don't want a shelter here.' So, then we have to say, 'Well, it's actually not a shelter it's permanent affordable housing.' And still there's this fear factor of 'those people' moving into my block." Breaking Ground attempts to ameliorate these negative NIMBY feelings through "being a good neighbor" and by having "some sort of greater impact on the community both because everybody is worth it" (As stated in Ms. Rosen's story).

Two studies conducted by Linda K. Frisman and Robert Rosenheck (1997 & 1999) analyzed access to economic and public services for persons with mental illness. In January 1997, the federal government under the Clinton Administration implemented "Public Law 104-121 which eliminated eligibility for SSI and SSDI on the basis of alcohol and drug disorders" (p. 527 Rosenheck et al., 1999). This impacted the findings of the study published in 1999, because many of the clients which were served by the programs being studied were using SSI and SSDI to maintain housing and care. This law caused direct economic disadvantage to individuals who are dually diagnosed with a disability or mental

illness and who suffer from drug or alcohol addiction. The study conducted in 1997 was directly analyzing the impacts of whether or not the suspicion that disability payments exacerbate substance abuse due to the fact that, "the law was passed because of protests that disability payments may fuel substance abuse" (p. 792 Frisman and Rosenheck, 1997). It is notable that this study did not find that individuals who received SSDI were using the funds to purchase drugs or alcohol. Public Law 104-121 is a striking case of public stigma impacting legislation.

Deinstitutionalization and Homelessness

Eric J. Novella's study (2010) based on social systems theory is inextricably linked to the theory of stigma and social impact on mental health systems, specifically before and after deinstitutionalization (Novella, 2010). Similar to my own research, he studied the paradigmatic shift away from the asylum-based model toward a model of community-based care. His work analyzed how those who were discharged form institutions became "others" in the community, exemplifying the "principles of center and periphery" (p. 415 Novella, 2010). This essay discusses the origins of mental hospitals (asylums) as an attempt to reframe the stigma which was ubiquitous to mental illness by creating hospitals with a goal of inclusion into society. As we have seen, this goal was unsuccessful and Novella remarks on this as well. He defines modern psychiatry and the community-care model as the recognition that mentally ill persons are individuals with rights who deserve specific care, but he sees this care as limited. Ultimately Novella believes, "the bitter irony of the whole project of deinstitutionalization and reform of mental health services of the last few decades is precisely that it was a response, in part, to societal concerns about the conditions experienced by long-term residents of the old mental hospitals" and he does not believe that the individuals who most need the help are receiving it (p. 424-425 Novella, 2010). I would agree to some extent, however as I have found in this research process, there are efforts to allay this concern. Novella also touches upon the second motivation of NIMBYism concerning advocates and the rights of mentally ill individuals. Deinstitutionalization is more of an un-development NIMBY issue, the dismantling of this programmatic infrastructure which causes the outcry of the public who are vocal against the release of "undesirables."

A study conducted by Shepherd et al. in 1996 mirrors Becky MaGuire's testimony that individuals who needed to stay in the institution, stayed. The study compared the quality of care given in the hospital to the care provided in the community and the patients' quality of life in both settings. This

study was conducted to determine the viability of community-based care in contrast to institutions. The largest finding was that the "most disabled patients were still being looked after in the hospital" however the study found that this care was more restrictive and led to a decreased quality of life for the patients because of their "lack of basic freedoms and their inability to influence the running of the settings" (p. 454 Shepherd et al., 1996). The article went on to suggest that future studies be conducted in regards to staffing at both locations. After speaking with Ms. MaGuire, it is apparent that the staffing is contingent upon the administrator doing the hiring. It is highly improbable that most large institutions would hire staff in the personal and efficient manner as described by Ms. MaGuire. Jessica Katz would also agree with this resourcing question with regards to deinstitutionalization and care. In her interview she stated:

> For a decade or more [deinstitutionalization] was the primary driver of homelessness in NYC at least. It's deinstitutionalization, it's criminal justice policy, the history of how we do or do not provide health care in this country, and then I think the latest trend that is impacting this is I think the medical establishment is starting to see that the highest, the most challenging piece and the most expensive piece for the medical profession are folks who are in the behavioral health world do not have housing. I think these days it's not uncommon to hear someone in medicine or public health talk about how medicine is not the best or only the only tool people for a lot of people in this situation and without a so-called prescription for housing, they can't help people. Looking at housing as the primary goal. There's a framework in psychology called Maslow's hierarchy of needs, that's been core in psychology, but people don't think about it as much in medicine or urban planning until recently that until you have a place to live, similar to say a housing first model. Housing first was a little bit slow to catch on in New York City because it [in a way] sounded like a permissive approach but really, it's based on a pretty core concept of human development which is that if you don't have your basic needs met you can't go to the next level and talk about your personal development or maximizing your capacity as a human being. So why we expect somebody to change the most difficult barriers that they face to reach their full potential and say, "once you have done those things, then we will give you a roof over your head," it's just not how the human brain works. So, I think those fields are increasingly coming together a and a lot of what both the housing, the medical and public health intermediaries look at overlap between healthcare and housing a lot of that ends up centered around behavioral health in a way that we sometimes talk about and sometimes don't. But overall that's the most challenging and most expensive place. I wouldn't be surprised with the current opioid epidemic if that gets even more traction.

In an article published in Social Psychiatry, Trute and Segal (1976) studied social integration based upon census tract predictors (Trute and Segal, 1976). The article focused on the effects of neighborhood organization on individuals who had recently been discharged from institutions and their ability to integrate into their communities. Trute and Segal compared two urban localities known to have differing environmental circumstances and also shown to have differing circumstances in their

census tract data. Their goal was to determine if there was a formula for the "supportive community" best able to enhance social integration for the recently discharged. The findings are consistent with what Brenda Rosen and Kristin Miller discuss with regards to supportive housing. In particular, the study found that "the 'supportive communities' appear to be those in which there exists neither strong social cohesion (high social organization) nor severe social disintegration (low social organization)" (p. 159 Trute and Segal 1976). The authors suggest that program planners use their findings when selecting an area in which to develop a shelter or in this case a supportive housing development (p. 161 Trute and Segal, 1976). However, according to Ms. Rosen finding locations in which Breaking Ground can develop a building notwithstanding the census tract specifications is challenging enough due to the cost of land. Furthermore, from the narratives the impression one gets from supportive housing is that the goal is to aid in creating a supportive community, like the ones described by Trute and Segal.

Homelessness and Mental Illness

Sosin and Grossman (1991) looked critically at studies that have linked homelessness to being recently discharged from an institution (Sosin and Grossman, 1991). They (in accordance with Dr. Hopper's interview) do not believe that deinstitutionalization alone is the cause of more homeless mentally ill individuals. They found that a more tangible cause is that "resources are difficult to obtain in this time of fiscal retrenchment and because mental health workers do not always have the necessary time or training" to find stable financial resources (p. 338 Sosin and Grossman, 1991). The study moderately contradicts the opinion of Jessica Katz, as well as my own assumptions, that while deinstitutionalization plays a role, it is not the leading cause as I had believed. Hurlburt et al., conducted a similar study (1998) analyzing the access to adequate housing for the mentally ill homeless and found that mental illness was not the reason for homelessness, but more importantly the limited access to affordable housing and the means for attaining housing were inadequate. Their study showed that given the opportunity, most mentally ill individuals are capable of maintaining stable housing (p. 307 Hurlburt et al., 1998). However, neither study questions the constant and increasing presence of mental illness amongst the homeless. Jessica Katz would agree with Hurlburt et al. (1998) that homelessness and a lack of affordable housing are not contradictory, but she would assert that deinstitutionalization played a more direct role than the authors or other scholars would claim:

> People became homeless because they were deinstitutionalized and there was nowhere for them to go. Those are the same to me. Frankly there are, particularly with the deinstitutionalized population, a good set of people who could not remain housed but for the social services that supportive housing provides. The cost of rent is one factor that

> was not the only thing that was preventing people [from stable housing]. We saw high rates of homelessness among deinstitutionalized people even at times in NYC when the affordable housing crisis was not where it is today. There's definitely folks in that population who you could give them an apartment for less, but they couldn't maintain that apartment without the social service structure that supportive housing provides. And ideally, we get the referral process and the targeting for supportive housing to the point where we're only housing in supportive housing those individuals but for the social services could not remain stably housed. That's what you hope for. Because if someone can make it on a Section 8 voucher then we should just do that, because supportive housing is a pretty resource intensive intervention.

A study conducted in the early years of deinstitutionalization (1984) looked simply at whether or not homelessness is a mental health problem at all (Bassuk et al., 1984). The study was a one-day census of a single shelter located in Boston, and created a demographic profile containing age, gender, mental health history, substance abuse, and diagnosis of the residents of the shelter. In this small sample the authors found that mental illness and/or history of residence at a psychiatric institution was present in the majority of people surveyed (p. 1547-1548, Bassuk et al., 1984). They cite the detachment to social and familial networks as a common theme in the mentally ill homeless. However, they note that "one-fifth to one-third of the homeless had been psychiatric inpatients" which is smaller than they expected "if a relationship does exist between the increasing numbers of mentally ill homeless and mental health policy" (p. 1549 Bassuk et al., 1984). More than a decade later, Sullivan et al. (2000) conducted a similar study analyzing the pathways to homelessness among the mentally ill (the article of the same title; Sullivan et al., 2000). They found that the growing homeless population is due to a combination of factors including "structural changes (e.g. declines in low-cost housing stock, reductions in entitlement, and growing numbers of persons in poverty) and individual vulnerabilities (e.g. mental illness, substance abuse)" (p. 444 Sullivan et al., 2000). An important aspect of this study was the identification that homelessness can be a cause of mental illness or exacerbate mental illness or proclivity to substance abuse. However, in general they found that homelessness is simply most common amongst "impoverished and disadvantaged" individuals regardless of their mental health status (p. 448 Sullivan et al., 2000). They do conclude, however, by stating that the relationship between mental illness and homelessness is complicated and dynamic, a theme echoed in the oral histories.

In a 1997 study conducted by Kim Hopper and a team of professionals and researchers analyzed the effects of the institutional circuit on "frequent flyers" in the process of transinstitutionalization and the potentially harmful impacts of increased access to the shelter system (Hopper et al., 1997). Hopper et al. posit that traditional studies of the homeless and mentally ill sub-cohort are analyzed through the

lens of the “push factors” such as challenging housing programs and an over complicated bureaucratic process. This study analyzed the “pull factors “which might lead a mentally ill individual to chronic homelessness. The pull factor focus is that “homeless service systems should be viewed as independent agents shaping the course of homelessness… perpetuating, rather than arresting the ‘residential instability’ that is the underlying dynamic of recurring literal homelessness and that so often harries the lives of persons with severe mental illness” (p. 660 Hopper et al., 1997). Hopper et al. see this as the ineffectual nature of politics and the ever-changing system, legal framework, attitudes of the public and politicians, and policies there is an increased risk of never acquiring stable housing, this then draws perpetually homeless individuals to rely on shelters or the street, factors which have remained more or less constant. Becky MaGuire discussed the loss of institutional knowledge and how the fragmentation of services can lead to inadequacies in care, and this experiential evidence parallels this study conducted by Hopper et al. Ms. MaGuire worked in the traditional institutions but in response to deinstitutionalization was pressed to find “creative solutions” for the provision of housing and care for those deinstitutionalized individuals. Hopper et al. define this as the institutional circuit, alternative institutions “pressed into service as functional equivalents of asylum in the wake of widespread deinstitutionalization” (p. 662 Hopper et al., 1997). In further connection to Becky MaGuire, Hopper et al. highlight the struggle she faced in her career where “relevant agencies tend to have parochial ideas about their proper domains of work” and this impedes the success of agencies and organizations and individuals eager to help (p. 664 Hopper et al., 1997).

A study conducted in North London (Trieman et al., 1998) of the Team for the Assessment of Psychiatric Services (TAPS), a community-based health care housing program, found that a history of homelessness leads to greater risk of future homelessness. The study was specifically designed to analyze the effectiveness of community-based healthcare and housing in providing housing stability five years after the program was started. This study suggested that in order to mitigate this risk, community-based health services should be adequately supervised. The findings call for well-resourced alternatives that are carefully planned in order to prevent mentally ill homeless persons from falling into the institutional circuit and therefore impeding their access to more stable housing (p. 416 Trieman et al., 1998). The supportive housing programs as described by Mss. Miller, Rosen, and Katz suggest that supportive housing is such an alternative.

Amidst the many themes presented in the oral narratives was that of employment and providing more than housing. Kristin Miller focused on this point heavily in her discussion. Becky MaGuire and Brenda Rosen each also discussed the importance of income for individuals in maintaining housing, and

access to medicine and care. It is apparent that in order to effectively reduce chronic homelessness, employment plays a role. Polak and Warner (1996) study the potential incentives and disincentives to work that are fostered by subsidized income programs such as SSI, SSDI, housing subsidies, and food stamps provided to people with serious mental illness (Polak and Warner, 1999). Kristin Miller would likely agree with the gentlemen in their discussion pertaining to increasing the capacity of mentally ill and/or disabled persons to attain work. However, the study applies a global scope when considering the employment of mentally ill persons and found that economic opportunities like "social firms" and affirmative businesses" which operate in Germany and other European nations have the ability to truncate unemployment amongst the mentally ill.

Housing Programs and Efficacy on Target Population

As stated previously, several studies exist which analyze the impact of Section 8 vouchers and subsidized housing on reducing homelessness for those living with mental illness and/or drug/alcohol addiction and/or abuse (Newman et al., 1994, Hulburt et al., 1996, Dixon et al., 1994, Siegel et al., 2006). However, I was unable to find any study which, as Kristin Miller suggested, bolster the success of supportive housing programs; studies which focus on the benefits of the community which plays host to the supportive housing building. In a comprehensive comparative analysis (2001) of the literature regarding programs designed to ameliorate homelessness in general, the authors note "although supportive services for people with serious impairments are valuable in their own right, they should be justified on grounds other than the preventions of homelessness, from which the perspective most such services will be wasted" (p. 113 Shinn et al., 2001). The literature regarding the study of such programs and projects begins in 1994, a decade after formal deinstitutionalization, and is on-going. The early articles analyze the effects of access to Section 8 Certificates/Vouchers by mentally ill homeless persons and whether this improves access to housing. The second wave of studies in the new millennium focuses more heavily on the types of housing programs available and in more recent years the addition of other elements, such as access to capital, which have been identified in the oral histories as vital for the severely mentally ill in remaining stably housed.

Newman (1994), Dixon et al. (1994), and Early (1998) separately conducted studies on the effects of access to Section 8 Certificates and successful attainment of housing of mentally ill homeless persons. All three studies found that individuals who had access to Section 8 Certificates were more likely to remain housed longer, however they each individually cite many problems associated with the Section 8 program despite this improved access to subsidized housing. Dixon et al., noticed that despite

stable housing many participants noted a decreased quality of life due to loneliness and feelings of isolation, and if given the opportunity participants were more likely to live in the same apartment building (p. 1200, Dixon et al., 1994). Newman found concurrent results however in a different way, by analyzing the "neighborhood problems" as a variable and identifying that the increase or decrease in this variable "may be a proxy for a tolerant community" this relates to the lack of social cohesion and stigma faced by mentally ill individuals (p. 195 Newman, 1994). Early (1998) did not isolate mentally ill homeless in his study, however he did analyze the assumption that subsidized housing is occupied by individuals with the highest risk of being homeless, a sub cohort which we have seen includes the mentally ill. In his study he does mention the mentally ill as a faction of about 30 to 40 percent of the homeless included. Kristin Miller would agree with Early's assumption that the "overrepresentation of the mentally ill and chemically dependent among the homeless is due to a lack of earnings potential" (p. 691 Early, 1998). Early substantiates Mss. Miller and Rosen's opinions that housing alone and increased subsidized housing cannot have much effect on homelessness. He goes on to state that these programs are "too poorly targeted on those households most at risk of becoming homeless" (p. 694 Early, 1998).

Relative to these three studies, Robert Rosenheck et al. (1999) conducted a study on the joint initiative of the Social Security Administration (SSA) and the Department of Veteran Affairs (VA) to improve access to SSI and SSDI benefits among homeless veterans with mental illness. The primary result of the study was not related to the SSI and SSDI benefits but instead to the impacts of the "colocation of staff from an income support agency with clinical staff from a specialized mental health program" (p. 527 Rosenheck et al., 1999). They noted the "lack of interagency coordination" as a major barrier to services for the mentally ill homeless. This same issue was identified by Becky MaGuire and Kristin Miller. Rosenheck (2010) revisits this focus on systems integration a decade later and continues to press that "complaints about mental health, health systems...for homeless people in particular is that they are fragmented" (p. 20 Rosenheck, 2010). This mirrors the career paths of Ms. MaGuire who was working in the field years before Ms. Miller, and yet they both say that there is a lack of communication and coordination between departments and agencies.

The Housing First model has been studied and discussed individually and as an aspect of supported housing programs in New York City. The inventor of Housing First, Sam Tsemberis and colleagues conducted an early study of the paradigm offering critiques of the Continuum of Care model which begins with outreach, followed by treatment and transitional housing, and then ends with permanent supportive housing noting that the requirements of being stable and clean are "incompatible with consumers' priorities and restrict the access of consumers who are unable or unwilling to comply"

(p. 651 Tsemberis et al., 2004). Becky MaGuire discovered her own personal issue with this philosophy early in her career as well. The Housing First program is predicated on the assumption that housing is a right and the homeless want to be housed; and the only thing impeding this is their capacity to enter the housing system because of their mental illness and/or addiction that limits their access to funds. I think that this model does exactly what Shinn et al. (2001) argue for: it focuses on the individual and is designed specifically for those most in need of that specific aid. Newman and Goldman (2008) comprehensively analyze the Housing First model with the goal of proving that it is necessary to have housing and services combined. They agree that housing should come first, but they work to prove that housing alone is not a solution for many individuals, and that without the supportive services integration, individuals have the potentiality to lose their housing (p. 1246, Newman and Goldman 2008).

Studies concerning supported housing programs and the Housing First model emerged simultaneously in the first ten years of the new millennium. Sandra Newman (2001) conducted her supported housing study on the housing attributes of housing projects for the seriously mentally ill. She collected studies from the 1970s until early 2000 and was primarily concerned with highlighting the overlap and gaps in the research. Her findings were that independent housing was associated with greater satisfaction (p. 1310 Newman, 2001). Newman also found that research pertaining to housing and practices for mentally ill homeless were not well documented and suggested various areas of study (p. 1316 Newman, 2001). Another study of supported housing (2003) compared two types of supported housing, “housing as housing” and “integrated housing” to determine the similarities and the difference (Hopper and Barrow, 2003). The dominant difference between the two programs is that “housing as housing” focuses on normalizing housing as fundamental element to “autonomy and self-determination” which means that the onus for creating social cohesion is on the participants, whereas “integrated housing… ‘builds community’ both within a housing site and more broadly” (p. 51 Hopper and Barrow, 2003). The authors see error in both programs. Despite previous studies that show social isolation as an apprehension for individuals living with serious mental illness, Hopper and Barrow (2003) do not see integrated housing as a more elevated approach, as it has implications that this program perpetuates “special pleading,” or the “my clients are more needy than yours” ideology, which in essence can limit autonomy and self-efficacy efforts (p. 54 Hopper and Barrow, 2003). After speaking with Ms. Miller and Ms. Rosen it is possible that Breaking Ground has determined a way to bridge the gap between these two programs, allowing the opportunity for a “housing as housing” approach where tenants may find apartments in their own buildings, but there is also the focus on developing buildings

that actively seek to promote community. A study (Siegel et al., 2006) of tenant outcomes in supported housing in comparison to tenant outcomes in community residences further supports the idea that a supportive housing development program like Breaking Ground is more than just supported housing (Siegel et al., 2006). In this study, researchers found that "supported housing and community residences were markedly different in terms of… community integration and in rights of tenure" (p. 990 Siegel et al., 2006). The study found that residents in supported housing had more autonomy but also felt more depressed, whereas in community residence there was constant access to services and the tenants could not remain isolated in their rooms (p. 986 Siegel et al., 2006). However, Brenda Rosen has described the Breaking Ground model of supported housing in a way that combines these two seemingly separate models. Is Breaking Ground the answer to the supported housing, integrated housing, housing as housing, community residence question?

Discussion

Originally, my research and literary searches were conducted with the primary goal of aligning policy in the literature and the oral histories and the effects these policies had or have on the provision of care for mentally ill individuals, who may or may not also be homeless. However, the technique of snowball sampling left me at the whim of the individuals providing the contact of the next individuals with whom I would speak. I was thereby directed very pointedly down the avenue of affordable housing. I am not disappointed by this turn of events; supportive housing is an engaging and innovative tool in the field of affordable housing especially as a resource for permanent housing for those with mental illness. However, if I had had my way I would have focused more heavily on mental health service provision and stigma surrounding mental health services specifically, though I do believe that affordable housing is exemplary at showing the palpable nature of this stigma.

I reached out to several agencies including the Department of City Planning and the Department of Homeless Services. The former never contacted me in return and the individual I was suggested to contact did not respond to the two follow-up messages I left. Furthermore, when I attempted to reach out to professional urban planners directly, I was directed to individuals in other fields (mainly psychiatry or public health). On more than one occasion I was informed that the topic of mental illness on the streets is not a planning issue. It was not until Kristin Miller put me in contact with Jessica Katz that I was able to speak with a planner who was working in the field. She too found it disheartening that more planners were not willing to participate in this discussion and has always seen her career as an integral aspect in the intersection between behavioral health and housing. Another limitation, is the

matter of interview subjects entirely. I had originally wanted to interview at least one mentally ill homeless individual; however, I was not able to do so due to limitations in approval.

This paper spent very little time discussing the institutional circuit otherwise known as transinstitutionalization but does recognize that this is another aspect at play in the socio-economic and socio-spatial relationship mentally ill individuals have with housing and care when they are homeless. I suggest further studies be conducted on the number of individuals who have a mental illness and live chronically homeless and who have been incarcerated or who are incarcerated as it compares to the general population and also the population of individuals who live with mental illness and stable housing. It appears intuitive to me that there is a direct relationship to the status of homeless and incarceration, especially if you are living with an undiagnosed mental illness or do not have access to medication. The costs associated with the institutional circuit and the pressures on society to pay for this fragmented care outweigh the cost of housing programs like Breaking Ground's.

Historically (and very generally speaking), mental health institutions have provided inadequate care that often even perpetuated forms of brutality and violence on mentally ill subjects. Deinstitutionalization, when seen in this light, can indeed be understood as a "human rights" measure, as Hopper indicates. It would seem that a certain measure of social exclusion—what might be called "transinstitutionalization"—is inevitable without a more pervasive political and socio-cultural shift. Once mental health facilities are closed, then the mentally ill are policed and imprisoned. This would seem to contradict the supposedly humanitarian aims of deinstitutionalization. After all, it's impossible to disentangle the neoliberal politics of austerity from the goal of deinstitutionalization. In the 80s and 90s, the US government closed mental health facilities because doing so saved money (just like they did with welfare). It's unlikely then that the state will make public resources available to treat mentally ill homelessness (because of austerity).

A parallel can be drawn between deinstitutionalization and "decarceration." True "decarceration," abolition, or, indeed, deinstitutionalization will in fact require more public funds upfront because an expensive constellation of other systems and resources have to step in and take care of people in a more robust way than previously. The politics of this tension are in some sense about differing notions of freedom. Republicans often define freedom as liberation from constraint: no institutions, no taxes, fewer rules, greater autonomy. Democrats more often define freedom as agency for something else, which requires higher taxes and more rules in order to give citizens a safe, secure platform (or safety net) for experimentation and independence. This political squabbling over freedoms reflects my own inner battles in determining what the "correct" answer to

deinstitutionalization is. Supportive housing models like Breaking Ground offer a cost-effective solution to the housing-care crisis faced by the many of the deinstitutionalized and mentally ill homeless.

Implications in Planning

Mental illness is a planning issue. Planners work in a myriad of fields including housing, public health, public policy, community outreach and engagement, homelessness prevention, to name a few areas in which work as a planner intersects with mental health. Furthermore, planners work in a variety of scales from the micro to the macro, local to federal. Mental illness has been recognized and addressed by governing bodies for decades through policy reforms since the 1840s. The policy movement of institutionalization began at the state level, in which states created their own standards and systems for mental healthcare provision and was redirected to the federal level decades later. However, in this redistribution of power, an isolation of responsibilities has occurred. As echoed in the readings and the oral histories, communication is vital to any program's success. At the outset of my research I was eager to make contact with planners working in the field, to learn from their experience, but after being told that I was looking for something out of the realm of planning I became reticent to pursue planners directly. Despite this reticence I felt strongly and became more resolute in my own belief that planning and the behavioral health field (as Jessica Katz refers to mental health and substance abuse) coexist.

Planners can be and have been a connecting force on the ground for institutions to monitor and integrate health, housing, and humanity into programs and policies, as exemplified by Jessica Katz and her career experience. However, this may seem an intangible idea to some. As Kristin Miller suggested, a more specific avenue which a planner might take would be to conduct studies regarding the impacts on the community as a whole from a supportive housing development project. CSH and all other supportive housing programs are seeking out studies which can help highlight the benefits of supportive housing development programs that work to integrate all aspects of care and independent functionality into its core. Another area of study in which planning, and researchers can elaborate on is to create a profile of landlord discrimination and the types of discriminatory actions, in order to address the question of whether or not landlord discrimination is a barring force for permanent housing access of the mentally ill.

Other areas of potential future research include broadening the scope of the type of scholars involved. For example, when Dorothea Dix was first expounding the need for mental health institutions design was a key element; architects could look into the degree to which design of an institution leads to

rehabilitation and/or mental health stability. Urban studies could further analyze the way in which the city itself, as an environment for habitation can perpetuate or create serious mental health conditions. Historic preservationists can look into the repurposing of mental health institutions into "better" institutions for health and/or rehabilitation or as places of affordable housing or housing units like supportive housing or as centers for mixed-use development. Even if these areas have already been studied or are in the process of being studied currently, this is then another example of information sharing and accessibility.

Conclusion

John Locke, the political philosopher, described a person's right to life, liberty, and property (which then became the starting foundations of the American dream), where ownership of a piece of land, or a home, is the goal. A homeless person owns no land. This should not make them any less worthy of their basic human rights. Prior to even this 17th century philosopher, many cultures were nomadic in nature. Now, we see these nomads as vagrants, a blight on society. But we share our public space with these individuals. They may be on the train before you and will likely stay aboard long after you have departed. One could argue that it is more their space than yours. But the reality is that it is a shared space. Mentally ill individuals are not always aware that they are even located in the same space and time. They are simply trying to make it through life. If this public space is the only roof they have, then we have failed as a society. Psychologists, public health professionals, sociologists, anthropologists have all faced the issue of mental illness often as an addendum, as a supplemental reason for housing the homeless. But housing alone is not enough. The means to access independent funds are critical along with self-care and safety. We tend to look away from the problem rather than leaning into it, circumventing causal relationships between homelessness and mental illness. As planners we need to look at this issue because the mentally ill who may then become homeless are in fact housed by the public space and are therefore an interest of the public.

Everyone needs a roof over their head. They need a place they can call home. Even if it is semi-temporary, a time-frame which is contingent upon the individual. What stops a person from buying a house? Cost. What stops a person from renting? Cost. The free market is the new "survival of the fittest" where the fittest equates directly to the amount of money you have or can afford to borrow. And if you don't have any money saved or the capacity to borrow or even the capacity to maintain a constant income, you're out of luck. The federal government has housing subsidy programs in place. Cities and states use their individual powers to enhance this federal piggy bank, however we are consistently

seeing the rates of homeless individuals rise. Since the birth of the US Constitution, the right to housing has been a controversial topic, however this right was not explicitly denied either. The powers vested in the states have allowed New York to adopt its own form of right to housing as the right to shelter, however if it was bolstered by Federal policy, it would be easier to enforce and resource. Internationally, the right to housing appears in country constitutions, such as Kenya, and the United Nations has written provisions for the adequate right to housing but as of, yet these have not been adopted by all countries (see the Universal Declaration of Human Rights, 1948; HRW, 2018). It is clear that deinstitutionalization created a gap in the provision of not only care and medical assistance for mentally ill individuals but also a hole in the housing stock. An integration of the two in a safe, humane, and fair (that is to say, economically viable for all) manner is the most appropriate solution, supportive housing programs such as the ones created by Breaking Ground in New York City can be a model for such integration. This is particularly if we all agree that everyone deserves access to a livable space.

Appendix

Oral Histories in Full

*Single spaced text has been directly transcribed by the author.

Becky MaGuire:

It is apropos that I should start my interviews with Ms. Maguire. Her story highlights the great complexity faced by cities and states in responding to deinstitutionalization; and that is where I began my own literary research, at the start of deinstitutionalization. Becky Maguire has been retired for four years, to label her career with one title would be a disservice. She worked in various sectors and areas throughout the continuum of care. Her story also exemplifies the intricacies of the system and the necessity for what she called "institutional knowledge." She started her storied career as a teacher after getting her undergraduate degree in history education. She went back to her hometown where she taught during the day. Around this same time there had been a large deinstitutionalization effort and was enlisted to help run a local group home:

> The home was to be populated with three women from the community who were mentally retarded[11] and three women from the deinstitutionalization effort in the local institutions that had been there for years and years and years. That's actually how I started, the lack of success in that project is what led me to go back and get my [master's in vocational rehabilitation in counseling]. I had a woman who had come out of the institution and she had a cleft lip and palette that had never been corrected so trying to get her a job to be successful [was challenging]. She wasn't as handicapped by her mental [abilities], she could have done something from that perspective intellectually but her speech and appearance etc. [held her back]. I went to vocational rehabilitation at that time and I said, 'I need some help, so I can get her a job,' and they said, "oh well we'll repair it once you get her a job" and I said, "no well that's really ass backwards." So that was what led me to go back to get my degree in vocational rehabilitation.

After attaining her master's degree from Florida State University, Ms. MaGuire went to Miami for a year and worked at a workshop that housed about 100 individuals from the community and the local institutions. She was then offered a position 50 miles South of Tallahassee as the Executive Director for the Association for Retarded Citizens. She stayed in this position for another year before going to work for the State of Florida. While working for the state she also did work in vocational rehabilitation as a supervisor for the aging and adult programs the State ran. Then, she changed jobs again:

> ...Of all the things I had done they ended up offering me a job in children's mental health Something I wasn't really trained in, I wasn't particularly interested in, and I didn't know a lot about it...That was where I actually began my mental health career.

[11] Ms. MaGuire describes how this term was legally changed to what we know today as "intellectually challenged."

All kinds of interesting things happened with children's mental health at that time. According to Ms. MaGuire, the State of Florida had over 100 children placed in residential settings outside the state. The legislature had decided that they were a population of "gone and forgotten" children and they wanted to make an effort to bring them all home. The State of Florida issued an edict that all of these children were all to be brought back to Florida. Becky MaGuire ended up being one of the people who went out to all of the localities where the children had been placed and make a decision and then broker what those kids needed back in the state of Florida.

> It was kind of a remote program, I have always wanted to go back and figure out what the name of it was, but the program itself was, in my mind, something that was really way ahead of its time… The kids lived in cabins. They had a long building [where] they did all of their school work in. And what happened was, the staff, the caregiver staff, kept copious notes on the kids all day long… And if something would happen… if a particular staff person saw a particular interaction between kids or staff and kids or whatever, they would make a quick note, jot it down, and put it in these mailboxes [they had all over the campus]. At the end of the day the night shift would go around and collect all the information from the mailboxes. This was so early on, [but] they would input it all into a system, that was open the next morning by the psychiatrist, who I believe was also the owner of the program. He would look at all of it and take all that information [from a] 24-hour, short term basis and determine what program changes or moves or successes they would have with each individual kid. Probably the most poignant thing that I saw in that whole program, [occurred] if there was a situation where a kid was acting out. It was the first time the lightbulb went on for me that it didn't matter how good the program was, or what kind of fancy buildings or degrees or anything else that anybody in the program had, if somebody recognized that a child had a particular issue that day they would take a string and tie the string to the wrist of the child that had the issue and take the other end of the string and tie it to a staff person. Basically, the message was, "I know you're struggling today, I know you're having a problem, I'm only as far away as the string because I'm the one who can make the difference for you today." And it was just amazing to me to see what kind of a difference that made. And as we go on and learn what we learn, particularly about kids and or adults who have mental health issues that acting out in many, many cases are "I just want a little more attention, I don't know what's happening to me, I don't understand really well and if you can help me as I go through whatever it is I'm going through then that's going to help me a little bit more." And it was so different from the huge Brown School programs and Devereaux and the other places that I visited that were probably to their benefit there was some counseling that went on, but there was so much medication therapy that went on at that time. So, to see what kind of a difference that kind of a program can make, in many cases with those kids I was greatly disappointed to bring them back to Florida and out of the program because I saw them as successes.
>
> But at the same time, kids had been in programs for years and years and years. And basically forgotten. One of the great challenges at that time was to get the schools to contribute their FTEs, their full-time equivalents into the financial aid for any kid that went out. Florida was paying probably anywhere from 50 to 500 dollars a day for kids to be out of the state. So, it was a huge financial commitment. When the state drizzled the money

> down to local areas you had a specific budget and you could only spend that budget and if 10 more kids came after you committed your budget for the year it was a done deal.
> I left the local area and went to the State program office of children's mental health. And began to administer the programs that we had actual setup and oversee the local areas from the perspective of oversight monitoring etc. at that time the unit that I was working I Became the supervisor of and the state mental health program office decided that it would not only serve children but there was a huge push for geriatric at that time. So, I developed the responsibility for geriatric. Which became another issue, because we had another issue of aging populations in the state institutions. From the perspective of their mental health they weren't getting' better; they were getting older and their needs were changing drastically. We developed specific programs... because, again, the push was coming fast and hard to fully deinstitutionalize the mental health hospitals and we were trying to get the upfront on getting ready to accept them into the community. I can remember getting called to the legislature, there was a particular problem in Jacksonville (on the far east of Florida). There is a state institution about 30 miles away from [Jacksonville] and there was a huge deinstitutionalization effort happening there. The city was up in arms because their homeless pop was beginning to grow, and they were trying to figure out how many of those people were coming from the institutions and what kind of planning the state was actually doing to successfully discharge individuals form the state institutions instead of adding them to the homeless pop in the city. So, I can remember being in front of a legislative committee and we were all like 'wait, wait this isn't working let's rethink this. What are you doing about it how are you moving?'

In her quest to bring the 100 kids back to Florida, Ms. MaGuire came up against push back from the institutions she would approach, she postulates that they were afraid of losing patients and consequently money. Their opinion was that Ms. MaGuire was not a medical professional and was therefore taking the children against medical advice. At this same time the State of Florida had an Educational Leave program, because the state was short in nurses, the program effectively paid an individual for the two years they were getting their nursing degree, but then that person would in turn work for the state upon graduation. Ms. MaGuire decided to take this educational opportunity but in order to qualify she had to be an employee at an institution:

> Anecdotally, I can remember going to court one morning and there was a little red headed African American lady in a hospital gown with her fanny hanging out the back of her hospital gown and walking with a walker and come to find out when it was all said and done, she had a PhD and she had been a professor of physical education at the local university. She had, had mental health issues, she was an alcoholic, and 'I was like wait a minute, wait a minute, this is the kind of people we're admitting into the state mental hospital? There's gotta be something else going on.' And I ended up working very closely with her sister who had married a diplomat and served in the Philippines and other places. Their father, the two sisters', was the first African American physician licensed in the state of South Carolina, so it was like 'whoa. This is going on?' So, I ended up working very closely with them and ended up finding a solution; she went into the institution for a very short period of time into the admissions unit and then was discharged and we were

successful in finding her a halfway house back in the community and helping her. It was amazing to me the kind of people we were talking about institutionalizing.

During that time, they decided to close one of the large units in the institution. The institution that I ended up working with closely was called Chattahoochee. And it was about 56 miles west of Tallahassee and it was previously a civil war munitions factory. So, it has a very stately ground. And from the perspective of a hospital it's not what you would think of as a one building hospital, there are probably 100 buildings on the grounds and many units. Today there are probably more forensic units and patients than there are civil. At the time that I was originally connected to them, when I was doing the admissions and discharges, they probably had about 1000 patients but across maybe 20 units of different kinds. They decided to close one of the units, both from the perspective of trying to meet the requirements of the legislature to close down or lessen the populations in the institution and budgetary. That was one of the ways the legislature was affecting what they were able to do and how many people they were able to house was [by] continuing to cut their budgets. So, they closed one of the larger units. That became a great part of my job because suddenly I had a great number of people that belonged to my local area and we needed to find other places for them to go, if they weren't subsumed by other units. People that really needed to stay in the institution stayed there and went to other units in the institution. But trying to develop resources in the community for these people that were being discharged were some of the greatest challenges.

There was a brand-new medication, Clozaril, and the drug companies had decided one of the places where they could have a defined population was in one of the institutions. The institute had a working agreement with the drug company. It was experimental enough that we would do [blood work] labs every week on the people. The medication was incredibly expensive. But it was pretty successful, you could liken it to the early days of Thorazine; when Thorazine became kind of a magic drug. So Clozaril was a drug that they were working on. Well, interestingly enough, that became a population that got better and really improved and became people who could really be discharged. Yet here we were with this drug and we were reintroducing patients into the community, but we had a whole new need for resources in the community. We had to set up a place that had the capacity to draw blood on a weekly basis, [figure out] how we were going to pay for this experimental medication for the patients in the community and where were they going to go. So, we developed things like a drop-in center so that they could get their blood drawn and other things. While [Clozaril] was a huge resource inside the institution it became a huge challenge outside when we discharged those patients... I found all kinds of things in the way of challenges for the discharge for the patients coming out of the institution.

There was one guy that no one was ever able to identify, he was kind of a John Doe when he was admitted so there was no way to register him for things like Medicaid and Medicare and other programs because he didn't really exist. And basically, the information he had given us upon his admission into the hospital was all bogus info. He said, "I have a college degree from here" or "this from there," and we would spend hours trying to track down these false leads trying to establish this guy's identity and never did. So basically, what we did for him, I can remember taking him to a local boarding house close to the university and saying he needs a room, kind of on a wing and a prayer hoping things would move forward.

My goal was to go to nursing school. One of the guys we discharged wanted to go to Junior College. By that time, I had been around that local area so much that I knew a lot of the

people and I knew the guy that was the superintendent of the state hospital at that time and he said that particular patient had caused a lot of problems and was very vocal. Had had a license as a mortician so he was a very bright guy and he was always challenging everything the hospital had. For example, they wouldn't let the patients watch R rated movies on movie night, so he would challenge that. There was a committee that represented the patients and he was always going to that committee with a new challenge to represent the patients. I can remember the superintendent of the hospital saying to me "it's good for you to go back to school, but you're taking this guy with you," because he (the patient) had decided that he had wanted to be a paralegal, and they had a paralegal program at the junior college where I was getting my nursing degree and the superintendent said "he's going to be in your backpack you're taking him with you, we gotta get him discharged from this hospital." So, I worked a long time trying to help him with housing and get established.

Tallahassee doesn't have the greatest public transportation. So, there were so many challenges in moving people and I can remember there was one guy who had been an accountant and trying to get him back out of the hospital, ultimately, I convinced the hospital administrator to buy him a one-way plane ticket to Vegas. And we sent him there and he went door to door with his accounting credentials and eventually got himself a job. We had a lot of creative solutions that went on during that period of deinstitutionalization. But again, it was always one day and one hour that those discharges were successful particularly in making sure we had all the services we needed available to that person in the community. And of course, you're always dealing with Stigma. And trying to look at it from the perspective of "we have everything out there that you need and hopefully with the least amount of stigma associated with it." So, every year it was touch and go which community resources we had available and could maintain and continue to the people who were being served in the community.

Then I went to school for 2 years. I owed my soul to the state, Florida State Hospital, because they paid for my school for those two years. They needed staff in their geriatric unit. So, I went to the geriatric unit. And probably the greatest challenge of my mental health nursing career at that point in time was that was the advent of recognizing that there were so many individuals out there being diagnosed with Alzheimer's. There wasn't capacity in the local community to handle them, there was an unknown quantity, so we opened one of the first ever Alzheimer's units. I was in a geriatric unit that had three floors and six units. The floors were divided by gender until they decided to mix male and female for the Alzheimer's unit and the admissions unit. I worked in most of those units and there was a lot of research. The people that I saw in that unit had been such bright people, we had PhDs we had masters of talents, we had a man who had been a marine and then worked for IBM and had 10,000 a month in income but his wife couldn't find anyone to help serve him, so he ended up in the state mental hospital. That became a real issue. The behind the scenes things I did was help develop an Alzheimer's foundation and resource center for families. Eventually nursing homes and private care facilities were better resourced, as long as there was financial capacity the individuals were pulled from the state and put into these private facilities.

I asked Ms. MaGuire what her greatest takeaway from her career or throughout her career was and she presented me with several large themes:

> We had spent so much money on big glitzy programs for all kinds of people, and that [string anecdote] made such a difference to me and I used that as I went on in my career and said I really and truly believe that what it truly takes to make the difference for somebody is one other person caring about them. And making the effort. When I got the opportunity to be on the administrative side I would try to do that. Even in the geriatric unit, I worked with admin to develop a program where it didn't matter, you didn't have to be a nursing director or nurse or psychiatrist or psychologist or anybody else, I would pair up, I would see, especially when I worked the night staff, I would see direct care staff who really had connections with the people that they were serving. So, I would say to the direct care staff, because at this time nursing had oversight of the direct care staff, I would say "you have a particular connection to Mary, would you like to be Mary's advocate?" We would develop a program where, when it came time for the treatment team to meet on Mary the direct care staff member, from the night shift, became available and sometimes the treatment team would have to meet on the night shift because Mary was the most important person to the direct care staff. That went forward with me in my career. I felt that some pairing up of people [was critical]. It doesn't matter where you are in life, you connect with certain people and those people end up being your best friend, your advocate, your partner, your pal and it matters that they have an absolute personal interest in you. It can't happen every place you go but it became so evident to me that it was so important that there be that connection with people. All of the decisions are made at the top and this became important to me as I would hire people, was how important it was to hire someone that had institutional knowledge or had walked in the shoes of the person that we were trying serve in the programs we were trying to develop.
> Many, many times I took the same problems with me from one desk to the next. I would say today the same problems are still there that have been there. I blame that on the fact that you have so many of the people down lower in the system who continue to try to solve the same problems but the administration changes so often that it's a matter of trying to bring those people up to speed and you lose progress. They have different ideas of how things ought to be done. They continued to try to do things that had been tried and failed prior. We are losing the institutional knowledge.

She then relayed an anecdote pertaining to this institutional knowledge and the disconnect that existed and exits between administration and the clients/patients they are trying to help:

> I can remember we had an administrator who had come from Ohio who decided it would be a good idea to co-ed all of the units. Well the geriatric unit I worked in, the mean institutional time of those individuals had been 26 years, so they were people that were used to being in the institution. I remember two women specifically, one of whom had been admitted to the hospital in 1926 for what today we would say she had was postpartum depression, so to take her and put her in the same unit as a whole bunch of men at that time was completely confusing. They were refurbishing all the units… So, while they were refurbishing the second floor on the right-hand side of the building, they would move everybody to the left side of the building, which was the mirror image of where the patients had been. It was complete and absolute chaos. Trying to talk to [the administrator] and explain how things work was impossible. I always said 'you must come and work a night shift. You must live in the shoes of the people you are making the decisions for.' They installed restaurant style sprayers in the showers instead of shower heads for us to bath the patients. It would practically blow the hide off of people! So, I

> went to him and said I wouldn't shower elderly people this way. But someone along the lines said the shower heads came from the top, Tallahassee but I had worked and lived in Tallahassee, so I said 'no I'm sure Tallahassee has no idea what kind of shower heads are here' something that became very important in my career was having relationships with people I had worked with. By the time I got back to work the showers were changed. Institutional knowledge and all the different levels of decision making were invaluable in her career.

As a student of Urban Planning, I asked her where she thought planning could have the largest impact in the field:

> It's absolutely vital to have the community work together, there have been very successful programs but there have been programs that have failed for lack of this community cooperation. Looking at the resources that are available that are inherent that, they're there, take advantage of them and use them instead of thinking you're exclusive to the people that have the credentials behind their name.

Correspondingly she also felt that planners might aid in rounding up community resources, and I asked her to elaborate on what community resources meant to her in this context:

> It was incredibly difficult to find a psychiatrist who would work with someone who was dually diagnosed, who had no idea how to communicate with Medicaid or understand low- IQ or autism, or a pediatrician even, or a child psychologist who was willing to work with a behaviorist. Absolutely the school resources working with people. Housing and urban development, so that you don't have a Section 8 apartment that you move an individual with mental issues in that [the landlord] is going to evict them the first month that they have a manic outbreak. We worked with the HUD people. You walk that fine line where you have to ask are you giving out HIPAA kinds of information that you don't want them to have, again the stigma, or are you doing preparatory work so that when they have that first manic outbreak that they have the number to call the counselor or whoever that can be the difference between the person getting evicted for being admitted to a hospital or mental health unit. Those are incredibly important. Workforce. Because it's so important A: from the perspective of finances and B: from the perspective of general mental health and well-being of an individual, so they're not just hanging around the community with nothing to do and having difficulty paying for their medication. The capacity for individuals to be able to work and be worthwhile and not lose their Medicaid for their medicines that have helped keep them out of the system and mental health. We worked on occasion with the local people, way back when I had the group home, it was important to be able to work with local resource where you could connect them to a food bank or some place that could help get them proper nutrition, so nutritionists became important. We worked a lot with universities, also with junior colleges, where they were training dietitians and nutritionists and get those resources, which would not only be a help to the patients themselves but help to the institutions and the people getting the degrees who would be coming out into the community. It takes a village for sure. We worked with Churches, if somebody had a particular connection and they weren't able to pay their rent until their check came for the month that the church would help them. Again, you had that local support. My mom used to say when I first started and graduated

> from college, she said "I don't understand in my time (she was born in 1921) in my history the community took care of these people, we didn't have all these fancy things going on. The church took care of them, the community. We knew that person on the street who was 'different' and how to interact with them who their support system was, we became part of their support system. They were the people we expected to have to take care of." She was surprised at the amount of government involvement. Her idea on a basic level, was accurate.

Brenda Rosen:

On a chilly March afternoon, I walked briskly to the office of Brenda Rosen who is the President and CEO of Breaking Ground. Founded under the title Common Ground, Breaking Ground is a supportive housing program in New York City. Their Times Square location remains the largest supportive residence in the country and they have provided thousands of individuals with a chance to find a permanent home. Ms. Rosen shares her experience:

> When I started out, I initially thought I wanted to be a social worker I knew I wanted to impact change for the better and after doing an externship for the city council a long time ago and working with social workers, I realized that I wanted to take a different path. So, I ended up going to law school and focusing more on public interest type of law classes, constitutional law and my strength was not in corporate law or anything like that and I started working for the Department of Homeless Services. So, I started in government in the 90's working for the Department of Homeless Services as an attorney. But because at the time the DHS was a young organization it had been part of human resources admin and then broken off to be its own agency it was small, and it was new. What that meant was I and other people were given a lot of opportunities that you wouldn't normally get so now DHS is a very large institution the problem has gotten bigger and they've grown reasonably so, and they've actually merged back with HRA [Human Resources Administration]. But my sense is if you're an attorney you're working in the legal department and that's kind of where you stay. I was an attorney working in the legal department and doing that kind of as my day job, but we were trying so many new things out so many new programs that the agency was looking for help all over the place and I was young and eager to work. I ended up running the central intake center up in the south Bronx for homeless families, it still exists it's just a bigger much nicer building now. But any family that is saying that they are homeless and need a place to stay has to go to the family intake center on 151st street in the Bronx. I was asked to go up to that facility and develop a legal program to review to make sure we were making correct decisions about whether people were entitled to shelter or not and I was also asked to run the operation, which was completely different and something I had never done. I had a small legal department, so I went from 8 attorneys to about 400 staff 24 hours 7 days a week. I learned I was able to not only understand homelessness and the legal implications of being homeless and the challenges, but I was also able to understand a lot more about what people go through and why they're coming in and asking for shelter. Particularly, on the family side.
>
> Fast forward, after a few years of doing that, I received a call from the founder of Breaking Ground, who's no longer with us, she had gotten my name and wanted to talk to me about coming over and opening up what would have been our second supportive housing

> residence and that was in 1999. I met with her and basically, she convinced me. It was really interesting, I was going to be brand new I was going to be able to see homelessness and helping homeless people on the other end of things. I was on the front end of homelessness when you come in and you're saying I got kicked out of my house or I couldn't afford to pay my rent anymore. On the Breaking Grounds side, it was primarily single individuals from homeless, but they were coming into our housing and we were providing them stable housing and the supports with the goal of helping them start their lives over again, reunite with family, helping them become stable and never return to homelessness. I figured I'd do that for a couple of years and I go back to practicing law, that was 1999 and now it's 2018 and I haven't gone anywhere. So, my personal path is, as we, as this organization grew, and we built more buildings and expanded programs my role became the head of operations and my portfolio just grew with it. Then in 2011 the then President slash founder left the org to spin off a different type of org and I was asked to assume the executive position, so I did that in the summer of 2011 and I've been here ever since.

Ms. Rosen spent a large portion of the interview discussing Breaking Ground and the program's many strategies, advantages, successes, and also the challenges that come with developing permanent housing in a city as developed as New York. Her career in mental health and homelessness is inextricably linked to the story of Breaking Ground.

> And essentially what we started out as was an organization that saw a problem, saw homelessness as a problem that could be solved, and the solution was permanent housing. And permanent housing with on-site supports that, I always say, 'cohabitate with us in the building' so we primarily contract with social service providers to be in our buildings with us and Breaking Ground does the property management and we have a social service team that provides clinical services. I have to say that whenever I say Breaking Ground does the property management I feel as though I am sorely understating what Breaking Ground brings to the table in our buildings because in our supportive housing approx. 60% of the units are for formally chronically homeless people. The majority of those people come in with severe mental illness, addiction problems and sometimes we're working with people with HIV/AIDS. We don't require that anybody be sober, that they are clean and sober, to come into our housing. So, they come in with a lot of challenges and everybody from the security guard at the front desk to the housekeeper that's cleaning the hallways and seeing them every day to the social services team, are there to take care of the residents. The balance of the buildings, the remaining 40% are for low-income working individuals and those are roughly in our buildings that serve singles on the low end somebody earning 15,000$ a year going up to in the mid 30's. Some of those people end up needing services as well. When you're making 15,000 a year it's very hard to make ends meet even though now you have an affordable rent. So, we are there to help everybody in the building irrespective of whether you come in from being homeless or you're a low-income person.

Her confidence in Breaking Ground is infectious, I never professed to be impartial and I will confess that after this interview I was eagerly waiting to send my application and become part of the Breaking

Ground team, whose motto was once “ending homelessness” but even Ms. Rosen confesses this was a lofty goal:

> We did a strategic plan back in 2012 and we have changed our name and changed our tagline since then, at the time our tagline was “ending homelessness” we thought hmm number 1 you can argue that we end homelessness for each person that we are successful with, it was an ambitious tagline for us to have. But we also realized it simply did not make sense, if our goal was to move the needle on the issue of homelessness, and the numbers on the family side were just increasing and increasing and increasing, and our expertise is in building and running housing with supports, why would we not be serving families. So, over the last few years we have in our development pipeline we have buildings that are both going to have singles and families. Again, in a building with families a proportion will come from shelters because you don't find families out on the streets. And the other percentage of families will be low-income working families that need affordable rent. So that is what Breaking Ground does in sum.

Breaking Ground utilizes its unique position to not only help the community which will reside in its buildings but also the community in which its building will reside:

> We are looking to build in those neighborhoods to provide, not only buildings, but to be able to help improve communities in a much more holistic fashion. So, with every building that we build, we have something that is [for the community]. The buildings that we build are built with a focus on sustainable design. So, our buildings are LEED certified or Enterprise Green. We work with some of the best architects in the world, we’re really fortunate, and that does a lot for us. Number one when you’re going into a community and you have to sit down and explain that you want to build a building that's going to have 200 apartments, more than 100 of which are going to go to formerly chronically homeless people with mental illness and substance abuse disorder, people get afraid right away... It’s NIMBY, but our goal is to help communities understand that when you’re talking about Breaking Ground coming into your community and developing, the picture that you get in your mind should not be the traditional shelter that you think of as temporary [with] people coming in and out and chaotic and scary. Most of our buildings people walk by every single day and have absolutely no idea that that’s who we’re serving inside. We want our buildings to be assets to the community and not the opposite. And having a beautiful building that the neighborhood and the tenants can be proud of goes a long way. One of the best things we can do when we’re working with people out on the streets is, if we can convince them to just take a walk with us into one of our buildings to be able to say, “this is where you could potentially live” and “this is bob and he used to be out on the corner. The same corner you’re on and he’s been in our building for 8 years.” That is probably the best-selling tool, the best tool that we have in showing people that we can truly make a difference and that they are truly worthy of having a beautiful home. So, we believe in very beautiful design and sustainable design. And that’s what we build now every time. Additionally, we always want to have another type of give back to the community, so it may be a retail space, a community facility space, essentially means we’re able to rent it out at a very low cost. We want to bring in a strong not for profit partner that is going to be helpful to the community but doesn’t have the money to pay the normal retail rents. In a building in Brooklyn, that we have a 3000 sq. foot place on the ground floor. The Brooklyn Ballet is in that space and they're a not for profit. They

> serve children and adults in underprivileged communities and there's no way that they could afford the rent because we're near BAM [Brooklyn Academy of Music], in the Brooklyn Heights area and the rents are astronomical. So, there's no way that they could be there unless they were able to find a low enough rent and we were able to do that for them. In another building in Brownsville we have about a 3000 sq. foot community garden. We had to fundraise, but we were able to build out that space and now we have volunteers that come in and teach children how to grow vegetables and have all sorts of classes for the kids and grownups. We're always looking to be a good neighbor. To have some sort of greater impact on the community both because everybody is worth it, and it allows us to be able to come back into a community and say you know that building that's our building, we want to do another one down the street. We always make sure that when we find a piece of property before we say, "ok this is exactly what we're going to do" we go out and try to meet with all sorts of stakeholders in that community and say "what are you looking for? You have this piece of property, if you could do something with it, what would you build there?" An example of that is, in fall of last year we opened our first all affordable housing for families with children, 248 apartments in the Tremont section of the Bronx. And when we first designed the building, I forget what the breakdown of apartments was between studios, 1's, 2's and 3 bedrooms, but when we were thinking about it we kind of had it mapped out. And then we went and met with the community and we said, "we have this big piece of land, we're going to build a building here, what do you need?" and what we heard really clearly was that not enough landlords build large apartments. You can't stay; you have a couple kids and suddenly the apartment becomes too crowded and you can't afford another apartment. And so, then you're not able to stay within your community. More than 50% of units in that building are 2 and 3-bedroom units. Which in Today's market you don't find very often, especially 3 bedrooms. It's funny because as I walk the streets now I'll look at every sign about new buildings going up and more often than not I'll see studios and 1's, studios and 2 bedrooms, but not often do I see 3-bedroom apartments. And I think, "How? How is a family supposed to grow and be able to stay in that neighborhood in an affordable apartment If they can't raise their family there" So we try to meet the needs of the communities that we're going into. That's a long way of saying, that's what Breaking Ground is here to do.

I inquire about what she would do if there weren't any restrictions, if a genie could come and grant her development wish:

> To speak a little bit to if I had my wish list and what do I wish that we could do, at the end of the day I firmly believe that affordable housing - whether it be plain affordable housing with no services but the rents remain affordable and families can stay there and raise their families there or whether its supportive housing because people need more than just an apt with affordable rent - I think that housing is the answer to the crises that we're seeing in the city now. And we just cannot build enough housing or fast enough to move the needle as far as we would want. For a few reasons, the single biggest reason is that the price of land has skyrocketed in the city. We have looked at sites in east NY which a number of years ago people wouldn't think about going to east NY and now we are priced out of certain parts of that neighborhood. We have a building in the South Bronx on 149th street that we bought back in 2006 and opened in 2009 and the per square foot price for land has more than tripled in that area. There is no way that we could build that building now. So, what we are having to do in order to find land that is reasonably priced is we are

> finding that we are having to look farther away from public transportation and the people that we serve are not the people that have cars. So, it's harder. Now you might have to walk a few blocks to a bus to then take you to a train. Our building for example... on 149th street, is about three blocks away from the 4,5,6, 2 and 3 and a couple of letter trains also. It's right near the hub of transportation. But that is just becoming harder and harder.

She also spent some time discussing the governance of New York City and State and their ability to allocate resources which effectively allow Breaking Ground to function:

> People have often asked me why we are consistently developing, and that is true, but more often than not you'll see us opening a building this year and next year we hope to open another building, if everything works out, if our funding streams workout the way they're supposed to and we're able to find sites we can usually do a building a year. But I've been asked why don't you do 2, 3, 4, 5, buildings? And the answer is that we don't have, we're a not for profit, we don't have the funding, to be able to go and put down deposits on 5 different pieces of land. We don't have the balance sheet to go to a bank and say we want to build a 60 million dollar building and we want you to lend us the money, five times. We can handle basically one at a time. If tomorrow land was more affordable and we were given the resources such that we could do 5 buildings a year, we would be doing five buildings a year and we wouldn't think twice about it.
> And that's really where the city and the state, who play a massive role in all of our developments, the city and the state and low-income housing tax credits which are private investors are the key to our development. Both the city and the state have robust programs for supporting the development of supportive housing for homeless people. New York is unique in a few ways, NY is the only state in the US that has the right to shelter, so if you are homeless NY has to provide you a place to stay. Which is wonderful and a challenge in and of itself. But NY is also and has been also since I worked for the DHS and before then been very, very committed to long term solutions on homelessness. Despite the fact that the numbers are increasing. NY 15/15, which is operating in service dollars for the development and operation of supportive housing 15,000 units over 15 years is the cities program and the state has committed to doing 20,000 units of supportive housing over 15 years. The combination of the two, the 35,000 units of commitment is as far as I know unprecedented so it's not enough. I mean when you're saying you have roughly 13-14,000 families in shelter and then another 12-13,000 singles and then 4,000 on the streets and as you house people, people are becoming homeless, it isn't enough, but it is quite a commitment on the part of city and state government. There are a lot of great things and initiatives going on.

After Ms. Rosen shares her experience working in Breaking Ground with me, I begin to ask her my burning questions. We discuss, in brief, the right to shelter. It is my belief that housing should be a right, when you consider Maslow's Hierarchy of needs, shelter is amongst the ranks:

> I couldn't agree with you more. The other thing that we say is housing is healthcare… There are still nonprofits that require people to be sober or on medications to come into their housing, fewer and fewer, but when you're out on the streets and you're mentally ill... First off, if you have undiagnosed mental illness, you don't even know that medication can help you but let's just pretend for a second that you do know and not many people

> have, where they're sleeping, a refrigerator where they can then put their medication there are so many daily things that stop somebody from being able to be successful without a roof, and a secure place to sleep at night. I always say that to go, if we're out on the streets and we're meeting with people and our answer is, all you have to do is go find detox, rehab, find yourself some medication so that you are thinking more clearly and are sober and then we'll help you, we're doing a terrible job. That's an impossible bar to set. First let's get you nowhere you're not spending all your energy trying to figure out how you're going to make it to the next day. So that you don't have to worry about that so that then we can help you work on all the other things. And that takes time and that takes effort. But again, it takes less money than it does, you know, if you're on the streets and EMS is being called all the time and NYPD, you're using emergency rooms as de facto shelter because it's too cold on certain nights. So, it just makes sense.

I ask Ms. Rosen about her interactions with Planning and City Planning, I assume that if they are building apartment buildings they must work with City Planning often:

> We can build in residential zones. We often look though to up zone. We go to a piece of land that would only accommodate 40 units of housing we go into the City Planning Commission and we argue that we should be able to up zone and build 150 units of housing. So, we do that. And on occasion we will find property in a manufacturing zone and then go through the city process to get that changed to a residential zoning. We can't build everywhere, but we have had a lot of success in getting support to get waivers or change the zoning for a particular area. I think that our experience with the CPC is that they want to understand what the or how your development will fit into the neighborhood. How is it not going to be an eyesore? If you go into a neighborhood where originally, it's zoned for a few dozen units and you want to up zone for 100 then how is that going to impact all of the neighboring services, if it's families are you going to have enough seats in school, is it going to be too much of a drain on public transportation because there's more people. So, our experience is that we have to present to Housing and Preservation and we have to present to city planning what the vision is for what we plan to do and how we're going to address all the other ancillary impacts that our development will have and that if we can do that and it's reasonable they're very reasonable back.

Kristin Miller:

Kristin Miller, despite her extremely packed schedule, was able to meet with me almost immediately after I reached out to her. I had received her name from Dr. Hopper in a list of names he advise I reach out to. Ms. Miller is the director of the metro team for the Corporation for Supportive Housing (CSH), an organization which was founded in 1991 and whose mission is "to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities."[12] As Ms. Miller briefly explains in her story, CSH is an intermediary organization, acting as the link between programs, organizations, developers, and models

[12] This is a direct quote from the mission page of the CSH website accessed on March 16, 2018.

in housing and the policy and decision makers who can help get programs off the ground. CSH also works to reform and improve government systems, provide capital funding to build supportive housing buildings, educate and empower industry players, and lead and expand the supportive housing industry. Ms. Miller has been with CSH for nearly 13 years and started as a consultant, she has been in the position she holds now for five years. She says how she got here was a "windy road…"

> I have a bachelor's degree in social work from Augsburg College in Minneapolis. After college I got a fellowship in NYC, it was a 10-month fellowship; the NYC urban fellows program. And that program is targeted to recent college graduates who get positions in middle and upper management of government in NYC. It's kind of a matching process where you go through a list of possible placements and you select which ones you want to interview for and the contact person for the age3ncy that has posted for an urban fellows' position, they select who they want to interview and you both mutually pick each other. I ended up working at the NYC HRA, let's see if I can remember my title, I was the Special Assistant to the assistant commissioner in special services for adults within the human resources administration. That fellowship threw me into Mayor Dinkins' "5-year plan to end and assist homeless adults". The day I started, was a Monday, I was accepted the Friday before and told to report early to my job as we were going to Staten Island because the plan had been leaked to the Staten Island in advance. So, I was driving to Staten Island as I was briefed on my position and on the plan and was introduced the mayor's office Director of Community Affairs. And it never slowed down after that day. So, I was thrown into the politics of homelessness on my first day in the job.
>
> Through that plan I was working with executive government on a response to, so this was in 1991, and this is coming into NYC when the crack epidemic had hit the city and the homeless population exploded. And it was a new profile, if you will, of folks who were active drug users. That hadn't, to my knowledge, been seen before in this city. And it was also families; families hadn't been seen like this ever. (I ask what year this all started to grow) So it was really in the mid-80s when the crack epidemic the hit and the shelter population started to explode. And under Mayor Koch, in response they had to house these people, so they were putting them in armories. This was also the time when the Callahan Consent Decree was enacted, so that was mid-late 80s. So, the city was now newly operating under the context of Right to Shelter and the crack epidemic. And so, there were these huge armories, where there were 1200 people in the Fort Washington armory drill floor in cots and with security and it was not a good situation for anyone, clients, staff, everybody. So, when I came in they were trying to create an alternative and this was kind of boutique shelters that provide social services, it wasn't just, the phrase was "three hots and a cot," it included social services. Acknowledging that people had issues that needed to be handled, addressed, in addition to them needing housing. So, my job was to promote these boutique shelters in existence that were part of this 5-year plan; to promote that the administration was going to downsize the armories and create more of these shelters. So, my job was mainly in finding sites, which threw me into NIMBY; where I and a small group of people were going out to community boards and elected officials trying to say, "here's what this is" and people's reactions basically were "hell no that's not coming, those people aren't coming to my community" (generalizing). Elected officials were very nervous about everything. So, a lot of it was showing off what we were talking about, so I was taking different key stakeholders on tours of these "good" facilities,

these programs. And then politics continued where a young man named Andrew Cuomo, who had started HELP USA, which was an organization that ran shelters and built housing for families and they were some of the first family shelters that were created specifically for that purpose. His father was governor, and the governor and the mayor didn't get along so well and so Andrew was appointed to run a Blue-Ribbon commission to examine the plan. So long story short, nothing actualized the way anybody intended. But there were new shelters that were built, and budgets created that had social work staff and some best practices on serving at that time the homeless population.

I continued to work in the Mayor's office after my fellowship, lobbying the city council on general welfare issues and others... Then Giuliani won the mayoral election and I was let go, which is how it works. I went to a Community Development Corporation. So, I got more into the housing. This company had been around almost 100 years. They had kind of a settlement model, cradle to grave services and affordable housing. And they were one of the early developers and providers of affordable housing starting in 1905. So, it was pretty fun to go from that frantic, politics of city government, to more of a staid organization that had been doing this quietly for a long time. I got much more programmatic experience with a more community-based approach where you were working with people from in-utero to end of life kind of stuff.

After that I went back to city government as the special assistant to the Commissioner of homeless services. When I was at, under Dinkins, in city legislative affairs I worked on drafting and getting the legislation passed that separated the homeless services function from the huge HRA system. There were 32000 employees or something like that at HRA at the time, a number of departments like child welfare, all kinds of different, HIV/AIDS was a new division of them, the cash assistance division, and because this homeless issue was so growing, that government at the time felt that carving out their own agency and moving all of those homeless services to a specialized agency would be a better management approach. So, I worked on the legislature to separate DHS from HRA. Then 4 years later went to work for the Commissioner of DHS. I was at an executive level and then I went into program and was in adult services. And really focusing on the intake points for DHS, for single adults, I didn't work as closely in the program with families at that time. This was being done in the context of the Federal government and Clinton's Welfare to Work. At this time there was a Republican Governor, Pataki, and a Republican Mayor, Giuliani, and so I was tasked when I went into the program area at DHS in implementing welfare to work rules and eligibility really what it was, eligibility for shelter. And the city has constantly, I don't know if struggled is the right word, but it's very challenging implementing Right to Shelter In the truest form of right to shelter, anybody, you and I could walk into a shelter and say, "I don't have a place to live" and the city would have to give you housing. There had not been for then, what? 15 years, no policies in place to try and control that front door a little bit more to take a look to say "well wait a minute, Kristin, you make 50,000$ a year, I understand you're going through a crisis, but do you really need shelter? Can we figure something else out?" And say, "no you don't need shelter right now." But the city just had to provide shelter to whomever walked in the door. So, managing that system is so, so challenging. So, the federal law as interpreted by the state as interpreted by the city, gave the city some ability to take some control of the front door. And what was fascinating being every other county in the state, you applied for shelter through the welfare agency, there wasn't 24-hour access. Only NYC. So, if you're at 233rd street in the Bronx, you could walk in and do that but if you're on the other side and you're Yonkers, you have a totally different system. Trying to learn what

> others were doing, knowing we weren't going to have a day time shelter application system. But is there something else we can do? So, I worked on that for a couple of years and then the advocates, specifically the coalition for the homeless put a cease and desist order so I no longer had a role because they said, "no you can't implement any of these eligibility rules because it conflicts with right to shelter." So, then I just focused on "look we can always improve on that front door" and so I did a lot of training and rewriting procedures and policies and trying to train...train, train, train, train, train. Trying to improve on what we were doing.
> After that I went to a supportive housing provider. And I was working in the development department doing program planning and program design and the rest of my team were kind of the bricks and mortar people. And understanding how the capital planning and financing goes into creating supportive housing. And I would kind of come in with the program aspects, "who are we going to serve? What does the staffing plan look like? What are the resources of that funding?" and that embedded me in the supportive housing world in a way that I hadn't been before. And then I left there after a few years and was consulting. I had many different clients, I had government providers, service providers, supportive housing providers, shelter providers, CSH. I did some consulting for them and then ended up in this position.
> Oh, and in the meantime, when I left government to go to that CDC I got my master's in social work from Hunter College, focusing on administration and community organizing.

Ms. Miller's career covered a whole breadth of things. It is clear to me where her career would have intersected with planning but to be clear I ask her anyway:

> When I most closely worked with, literally City Planning was siting. So, Nimbyism and at CSH in particular, well rather from the implementation standpoint the sighting is a huge issue and politics. But I think what I've enjoyed here at CSH is talking about supportive housing as a community development, from a community development angle. So, we're very thirsty for some kind of research that shows the benefits of having this kind of housing in your community. The only thing we have is the Furman study which is now quite old. Everybody knows it, but we need more. And what we know is that, and I think that the beauty of supportive housing is that particularly in our urban environment, in our dense environment it's very easy for somebody for people to understand that we build apartment buildings. And NYC has been a lead in mixing, what we call "special needs units," the supportive housing units with affordable units. So, it's "normalizing" life for all of its residents. Any apt building in NYC has people with lots of different backgrounds and lots of different things going on in their life. So that's what we're doing. So, when we talk about the development of supportive housing and Jane Q. Public says, "oh we don't want a shelter here." So, then we have to say, "well it's actually not a shelter it's permanent affordable housing." and still there's this fear factor of 'those people' moving into my block. What we know is that it improves the real estate values, it brings stability to the neighborhood, the buildings are beautiful, they're run by mission driven organizations who care about the community, the fears of "oh you're going to serve women in this building? Oh well prostitution and I don't want the johns. And the drug dealing" and all of this stuff comes out. Outside of NYC more so than in the city is "well family housing? It's going to overburden my schools", so they come up with every reason not to [have supportive housing]. So, we are looking for much more research, documentation,

> evaluation, of the value of supportive housing in communities because we know it absolutely improves things.

Despite having stated in the main portion of her story that she thinks there is a hole in the data in regard to studies analyzing the impacts of supportive housing on the community, I ask her to reiterate where she thinks planners can have the greatest impact moving forward:

> The mission of supportive housing is making sure that the individuals are engaged in their community. So typically, what you find is that we build into the plans community space, rooftop gardens, courtyards in the back that we want people to use. So, the biggest tool we have, I find, in countering Nimbyism (I heard a term the other day making Nimbyism Yimbyism, yes in my backyard), is telling the community board "we know you struggle with a place to meet why don't you use our community space?" or "oh the girl scouts need a space? Come on over!" or "oh the AA needs a space to meet, come you can use our conference room." So really opening the doors and also empowering our residents to also become civically involved. So, making sure they know where the library is and if there's a place of worship that they want to go to, and you can go to the community board meetings, etc. etc.

I concede that I live in Washington Heights, one of the few remaining examples of a "tight-knit" community left in Manhattan, yet only after finding a job in my community have I truly felt a part of it. From what she has shared with me, I imagine that a supportive housing building, where part of the mission is actively engaging in the community, might inspire community engagement outside those who reside in that specific building:

> Yeah, that's what the hope is, right? And that's what I think quality supportive housing provider does. They have good relationships, a good one makes sure they have good relationships with the police department, the community board, the district leaders, the leadership of the community, and understand what quality providers are, whether that's daycare, mental health, substance use, library programs, just the whole. How can we connect people to the community and have the community connect to us?

As I have received her name from Dr. Hopper, who originally shared with the information regarding the *Olmstead* enforcement case whose mission it is to close down the Adult Homes in the city, I ask Ms. Miller what she knows or thinks of this litigation:

> Right, so I'm on the fringe of this, I'm not in it deeply…a person has the right to the most integrated setting for their care. I equate this to an adult home, their institutionalized and they and others believe they can live in a more integrated setting and they need the ability to do so, they can't be prohibited from doing that.
> (CSH) had been working on a federal level under the Obama Administration and with other key organizations to say "Hey! Supportive Housing is one of those most integrated settings." In a nutshell my colloquial way of describing supportive housing is, it's for people who are "sick" and need some "care" but not such that they need to be institutionalized but they can't quite totally be on their own at this time. So, they live in

this independent setting with these voluntary services warped around them, voluntary not required, and that is enough support, so that they can pretty much live on their own. But when something happens, there's somebody there to shore them up and maintain all the great things in their life. So, we know that there are people who are institutionalized in a lot of different settings who could thrive in supportive housing and I think adult homes is one of those places. So, there are people and I'm going to say some stuff now that I don't believe and I'm talking about what other people would say: it's kind of like, our society has always had its undesirables. So, whether we put them in jail, whether we put them in psych hospital, whether we put them in adult homes, whether we put them in nursing homes, (I say "or leave them on the streets and just ignore them"), exactly! Although that's harder to do because we have to step over them and they're literally in our face and we can't hide them away as easily, but we still do. We push them under bridges where we don't have to see them as much. So, pick your institution, we [as a society] do it, so I've been focusing a lot my work and CSH is behind this, in how do we break down those barriers so that people don't have to be in those settings. There are homeless people who end up in adult homes because they have a lot of needs its physical needs, so they're in a wheelchair, for example. But they're not accepted into other housing or other institutions because they're also actively using and/or mentally ill. So adult home operators will take them because they're on SSI or SSDI [Social Security Disability Insurance]. There is that piece. That's the most cynical version. There's also another version, where people go into these settings and they "recover" such that they no longer need that high level of care and is there an exit for them? So that's where I have talked to the adult home people to say we've got experience with this on Olmstead and also just with all the Medicaid changes under the Affordable Care Act and NY has been a leader in bending the cost curve and trying to get people out of the most expensive setting if they don't need it into a lesser expensive setting or type of care. So, there are people in the Manage Long-term Care System, which would be adult home/nursing home who no longer need that level of care, and trying to do nursing home diversion, adult home diversion, trying to get them into the community.

Now where it gets complicated and where I think that the world has not focused enough is the fear factor of the individuals. And I compare this to, we've done for a while now at CSH, a Moving on Initiative. It's taking the same concept, where people moved into supportive housing in one state and it (supportive housing) works, they're totally thriving, and they don't need that intensive level of services offered to them anymore, and they don't use them anymore. But because of affordability of apartments they can't move out. So, if we provide the rental subsidy for them to move out we can move them into an apt in the community just like anybody else and then backfill that supportive housing unit with somebody on the street who really needs it, or somebody in the shelter. What we found with Moving On, we've created this kind of assessment as with nursing homes and adult homes where there's an assessment of who's able to live more independently. Even if the individual we're looking at and the workers around them, the social workers, whomever it is, agree that "yep Kristin is a prime candidate for Moving On" actually from that moment to moving into an apt there's a lot of cold feet. It's what you know, it's what you're comfortable with, rather than this unknown, it's "I have these services, and I'm in this environment and I know I'm safe here" and so I think not enough attention is given to needing to work with the individual to have a nice safe warm handoff with aftercare and some assurances that "you're not going to be alone, there are going to be people and services around you to make this transition." So, in my limited understanding I think that's

> why these shifts from adult home managed long-term care into more independent [housing] have failed.
> There's another piece, why we've created this third-party assessment is that staff want to keep their great tenants. So, if I'm a lovely tenant and a pleasure to work with and I don't bother anybody and I'm just happy and a joy, then [staff says] "I don't want Kristin to leave. That jerk who bothers me every day that person should be moving out. But not the one that I love and adore."

I am curious about this "Moving On" process, if one of the goals of supportive housing is to enhance social cohesion and help build a community, are people more like to try and stay in that community even if they are ready to be completely on their own? And how likely are they able to afford their community outside the affordable housing?

> That's right, and what we're finding with this Moving On, if you moved into supportive housing in Brooklyn 15 years ago and you're a Moving On candidate, and we say "what do you want? You have a choice here!" and they're like "DUMBO!" we're like "yeah so does everybody… it's not happening." Right? So, there's this mix of expectations of "here's your income, here's what's available." And in fact, we've been moving people (when I say we it's the providers, we're an intermediary) through this program they can port their vouchers outside of NYC and a lot of people are. Now, I just heard on the news and I haven't had a chance to look into it yet, I think it was Broome County is suing the city because they're saying that NYC is dumping their homeless in Broome County. So again, it's shifting the "undesirables" and it's your people, it's my people, it's you people, it's the same story as always.

"Moving On" sparks another question, as discussed with Brenda Rosen, somebody who is in supportive housing has chosen to live there for a reason, curiosity strikes me again and I inquire about how many people are "moved on" because of the risk of relapse and other move mitigating factors:

> We really try to be clear, Moving On is for a very small number of people. So as soon as, typically, Government hears this they're like "oh my gosh I just see a 25% vacancy rate," and we're like "no, no, no, no, no, no, no." And it takes a long time and you have to be careful because even the process can be re-traumatizing. Trying to work with an organization, for example HPD, to get your voucher approved is a process. Having to go out and take your housing choice voucher and be rejected by landlord after landlord, after landlord, is pretty traumatizing. So, it takes a special person who is in a place of strength and then what we had as part of the initiative is a guarantee of aftercare and what we found is almost no one uses it. But the insurance, the reassurance is enough. And the providers are like "look we're always here". Now there is definitely consideration in that it is a one-way street, you can't move back into your unit once you've been placed out in the community. It's not an automatic "oh I want to come back", you can't. That unit has already been given up to somebody that's homeless. And you don't qualify for the unit unless you're homeless. But we have just been finding with this thoughtful process that people are doing alright. And again, it's small numbers we're talking. Over two years we will have moved 180 people from NYC supportive housing into independent living through voucher, there are over 30,000 units of supportive housing, so it's small. But 180 units is

> four or so supportive housing buildings we didn't have to build so we created that capacity without building.

It is clear that Ms. Miller has worked in a variety of sectors and has an expansive career in the field. I ask her what the biggest challenge is and where she thinks we are in terms of homelessness, supportive housing, politics, etc.:

> We're always going to have homeless people. I think the goal is to have the smallest system needed as possible, so that it's about flow. The smallest number of people are entering homelessness, they stay there for the briefest amount of time and quickly go out into housing. What I have found when a government - and take your pick whether it's a [small] town or LA - when a government gets the fact that when you look at your many different government agencies and you can say your clients are my clients, are your clients are my clients, we're all serving the same people; there's a huge amount of overlap. And [then] you share data and you identify the people who are using all the different systems you can start to make headway. You can start to make headway on less people entering homelessness, you can have top notch management of a homeless system to provide the right services people need to move out as quickly as possible. And when you have multiple agencies together you can have the right housing options for people. Where we encourage communities to begin is to find the most frequent utilizers of the most systems. So, when the Department of corrections, Department of Homeless Services, Child Welfare, and hospitals start to look at their frequent utilizers you're going to find that there's 500 people in common (I'm making up numbers here). Those individuals and families are experiencing poor outcomes because each siloed agency can't hold onto the person long enough to meet their goals to achieve the outcomes they hope for. They can't deliver the services the way they intend because they (the clients) keep going. It's a revolving door. The families, the individuals, certainly aren't getting the outcomes that they want because they keep moving from one system to the next. So, if they're in a 6-month program but in 4 months they get arrested then oops they failed that program, and then taxpayers are paying an incredible amount of money for duplication and disconnection of services. When you're able to coordinate and identify a person as they hop around, so it's person centered it's not systems centered, then everybody whether she's in jail, on the street, in the emergency room, we can find her we know where she is, we know where she is in her plan for her services and continue the care that she needs in order to get her stabilized whatever that means for her. It can mean a number of different things. So, my frustration in New York is that people aren't willing to do that.
>
> I think it's political, I think it's because we have one of the most mature shelter and housing systems in the country, so we have old walls that we've built. And it's huge. We have the most resources probably of any city in the country. So, the idea of changing, shifting, and sharing, means that some get less, and some get more and it's terrifying to some people or they can't even get their head around it. I think it's a little bit of everything.
>
> The Manhattan Outreach Consortium, which is all of the outreach providers in Manhattan, came together and on their own they created a database in 2007 that identifies people, puts in case management important info, and matches them to housing. They can get somebody into housing in two weeks, but if you go through the traditional,

typical way it can take two to three months. So, the question is it's been 11 years why hasn't this been brought to scale?

It's politics, its control, its money. I think there's also another piece too, when one starts to talk about data sharing there are advocates who get nervous and upset (HIPAA and health). It is my opinion that HIPAA is a very good thing, however HIPAA typically is used as a roadblock and that if the state of Connecticut has figured out how to safely share HMIS data safely across the entire state, I think NYC can figure out how to do it under one administration. We all report to the same Mayor. Where we've been able to make headway is to have people understand that you're sharing data so that somebody can get housing and help. So, you're saying that you can't tell this org or system about her substance abuse or mental health or whatever you are holding her back from getting housing. We need to know certain info because, again coming back to supportive housing, a typical supportive housing building could have 8 different sources of funding each unit could be funded differently, and funding is what dictates eligibility. And so, you might be a prime candidate but "oh I'm sorry your hair is orange, but if it was green you could be in this unit. Ah! But this unit over here you fit this unit!" But if we don't know what color hair you have, we can't help. So, I think that people lose sight of the reason why people are needing this information. And people have to sign confidentiality forms, and I know it's complicated, but I think that there is a way, there's got to be a way or people are, we can't do what we need to do. If you want it to continue to take 200 and some days to get someone into housing, let's carry on and watch the homeless system grow to 100000 people. And remember, too, it's the front end as well, so if you aren't mindful of diverting people. Who really needs this shelter, vs. who needs other things in their life?

I do question (and I don't know that it's right or wrong) all of these vouchers to keep people out. So, the city is paying people not to be in shelters. The link vouchers etc. NYC under Bloomberg started the advantage program which gave rental subsidies to homeless individuals for up to 5 years. At five and a half years, people came back to shelter. Now, when I worked in government, a day out of shelter is a day out of shelter. It "saves" the city money, you're not paying for that family to be in shelter that day. So, if that's the approach, then giving out vouchers is a day out of shelter. But there is, to my mind, not enough connection to the economy. In other communities, things like work investment boards, that workforce development, laborer connection, it doesn't really exist in NY. So, this idea that somebody is going to go out and their going to get a Duane Reade job and they're going to be lifted out of poverty such that they could afford, even if they're paying 50% of their income for rent, it doesn't happen in this city. SO, I think that we don't have a housing crisis we have an income crisis. For a number of people, it's not just the mentally ill folks from deinstitutionalization, although there are plenty of mentally ill individuals who have income who live in the community. But I if you think about that wave of people at the front door how many of them just have an income issue and not a housing issue? Paying their rent helps they pay their rent, but it doesn't help the income.

We at CSH over time kind of time and again have pushed workforce development. NYC never really bit. If you go outside NYC you go to the stop and shop big grocery store and you encounter people in supportive work, you don't' find it here as much. I'm talking out of little academic credibility here. Now what we have been, it kind of goes hand in hand with Moving On, doing is our folks are the bottom of the barrel (if you look at renting on the market) they have criminal justice histories, terrible credit, little education, little or no rental history, if they do have it it's probably bad they have evictions. We're working more, from this office in particular to make sure that supportive housing providers are

> not infantilizing their tenants. Despite that yes, they came in looking like, especially if it's a housing first program, directly from the street they're actively using, they're actively psychotic, etc. well yea that person can live independently but in order to do that you need to work with them to clean up their rap sheet. Our folks have lots of mistakes on their rap sheet. Can they get a certificate of good standing form parole? Like there's process for doing this. Can you clean up these warrants, there's ways to do that. You should be doing that from the first day they walk in your door. Also, credit, everybody deserves to be able to shop online, do they have a credit card, and do they have a bank account. And people maybe assume that because they're mentally ill, they can't do that. And we say no, that's not the case. Not everybody can, but probably a whole lot of people could. And that will only help them if there is a next step for them. And you can't get a job if you have a bad rap sheet and bad credit. You can't get a job. So how are you breaking down barriers for folks?

I can feel the time start winding down but ask Ms. Miller to impart any last words of wisdom that she has gathered over time:

> I absolutely think that we need to be building more quality housing. But you can't build your way out of this. So, unless we tackle this cross-systems work, and breaking down barriers anyway we can, the homeless numbers are going to be always far ahead of any of the solutions. It must be a bifurcated approach.

Jessica Katz:

Jessica Katz is the executive director of Citizens Housing Planning Council (CHPC) of New York City. She was recommended to me by Kristin Miller who thought Ms. Katz might be able to give me a planning perspective on housing the mentally ill homeless. I was sanguine about the opportunity to finally speak with a planner, and not just a planner working in the housing field but a planner who spent much of her career working at the intersection of planning and mental health care. Unfortunately, our interview started off in a discordant manner as the application I had been using to record the interviews was malfunctioning due to the inclement weather. However, Ms. Katz was agreeable and understanding despite this hiccup. I asked her, as I had with the other women, to tell me her story.

> My first job out of college was at a nonprofit mental health agency in Massachusetts doing supportive housing development. It was kind of perfect for me, I've always been at the intersection of social work and urban planning. But frankly I would have made a terrible social worker, so it was nice to find a niche of supportive housing development where I could do the work I thought was important but also play to my professional strength. I did that for several years then went back to get an urban planning degree from MIT. Where I wrote my thesis about people who had been bounced around various social welfare and criminal justice systems and kind of comparing folks who we kind of colloquially - we have this gallows humor in this business - we call them frequent flyers. So people who kind of get bounced around the homeless system, the criminal justice system, the substance abuse and mental health systems as well so I had a bunch of, I'm sure you can find it somewhere it was 15 years ago I'm not sure how up to date it is now, but I took a look at some publicly available datasets about mental health criminal justice and substance abuse

> and compared the types of folks who had heavy involvement in all of those systems with folks who just had one of those issues in their life. So, I was always kind of at this nexus between the social service system and the housing and planning world.
> Then when I finished graduate school I came to the city of New York and worked for the City of New York running their supportive housing loan program; loaning capital to not for profits to develop supportive housing all throughout the five boroughs. I worked for 12 years in city government and then very recently left city government to come work for my current position which is at the citizens housing and planning council, which is a housing policy think tank based in New York City. The housing and planning intervention for homelessness and behavioral health issues has been the main mission of my career.

Despite no longer working solely on homelessness and behavioral health, her new career with CHPC does contain similar overlap. Since 1937 CHPC's mission has been "to develop and advance practical public policies to support the housing stock of the city by better understanding New York's most pressing housing and neighborhood needs." The CHPC is a not-for-profit organization which brings together 90 professionals who work in a variety of industries all involved in housing development and management. As a community of professionals and expert research staff they conduct research and analyze the findings to assist decision-makers inside and outside government to draft realistic steps in changing the housing stock and the neighborhoods of New York City.

> The CHPC is a think tank in New York that promotes practical housing policies. We like to say that our client is the housing stock of the City of New York and that our goal is to advance practical housing policy and also to ensure that the housing stock of the City meets the needs of the population of the City. I'm no longer simply focused on homelessness and behavioral health, but obviously homelessness is one of the major housing crises that New York faces especially now. These days I have a broader role than just supportive housing; for 12 years at HPD I was mostly just doing supportive housing. Now I have a much bigger picture lens on the housing market overall, but homelessness is still my heart.

I ask her to elaborate on her career with the Housing and Preservation Department (HPD).

> I had a variety of different jobs but most of the time I was in charge of the supportive housing loan program, so I was loaning capital to not for profits to build supportive housing. It's pretty hands on. We had about 200 million dollars a year and we maintained a pipeline of up to 1000 units of supportive housing each year, that we loaned out to various not for profits to build the buildings. HPD doesn't build its own housing we're always loaning it to nonprofit and private developers, but we have intensive oversight over our loans.

I reiterate what I'm focusing on and explain how after doing the research and speaking with other individuals in the field I have expanded my assumption that deinstitutionalization occurred and therefore we see more mentally ill homeless persons. Ms. Katz states an opinion that is both supported

and contested by the literature but does also contend that it is more complicated than just deinstitutionalization alone.

> For a decade or more it was the primary driver of homelessness in NYC at least. It's deinstitutionalization, it's criminal justice policy, the history of how we do or do not provide health care in this country, and then I think the latest trend that is impacting this is I think the medical establishment is starting to see that the highest, the most challenging piece and the most expensive piece for the medical profession are folks who are in the behavioral health world do not have housing. I think these days it's not uncommon to hear someone in medicine or public health talk about how medicine is not the best or only the only tool people for a lot of people in this situation and without a so-called prescription for housing, they can't help people. Looking at housing as the primary goal. There's a framework in psychology called Maslow's hierarchy of needs, that's been core in psychology, but people don't think about it as much in medicine or urban planning until recently that until you have a place to live, similar to say a housing first model. Housing first was a little bit slow to catch on in New York City because it sort of sounded like a permissive approach but really, it's based on a pretty core concept of human development which is that if you don't have your basic needs met you can't go to the next level and talk about your personal development or maximizing your capacity as a human being. So why we expect somebody to change the most difficult barriers that they face to reach their full potential and say, "once you have done those things, then we will give you a roof over your head," it's just not how the human brain works. So, I think those fields are increasingly coming together a and a lot of what both the housing, the medical and public health intermediaries look at overlap between healthcare and housing a lot of that ends up centered around behavioral health in a way that we sometimes talk about and sometimes don't. But overall that's the most challenging and most expensive place. I wouldn't be surprised with the current opioid epidemic if that gets even more traction.

I explained that I had heard that the booming homeless population and subsequently the mentally ill homeless was from lack of affordable housing and not deinstitutionalization at all, but I insinuated that a lack of affordable housing would be a driver of homelessness in general.

> Right, well those aren't contradictory. People became homeless because they were deinstitutionalized and there was nowhere for them to go. Those are the same to me. Frankly there are, particularly with the deinstitutionalized population, a good set of people who could not remain housed but for the social services that supportive housing provides. The cost of rent is one factor that was not the only thing that was preventing people [from stable housing]. We saw high rates of homelessness among deinstitutionalized people even at times in NYC when the affordable housing crisis was not where it is today. There's definitely folks in that population who you could give them an apartment for less, but they couldn't maintain that apartment without the social service structure that supportive housing provides. And ideally, we get the referral process and the targeting for supportive housing to the point where we're only housing in supportive housing those individuals but for the social services could not remain stably housed. That's what you hope for. Because if someone can make it on a Section 8 voucher then we should just do that, because supportive housing is a pretty resource intensive intervention.

The bulk of my data is this oral history data. I explain that she's the only planner that I have been able to nail down to ask all of my burning questions, and she's doing exactly what I think and know planners can do, so I ask her how her planning skills have aided her.

> I think on the one hand siting supportive housing has become, over the years, sort of an expertise of mine and battling against the fear and the uncertainty and the NIMBYism frankly that happens when you try to site supportive housing project in someone's neighborhood and figuring out how to get past that and create some consensus. I think on the one hand having a planner's lens about how to get community buy-in, figuring out who the stakeholders are, and some of the things you learn in planning school around building community support and building consensus have been very useful to me working in a field where I need that to effectively build supportive housing on the ground. On the other hand, I think a planner's lens sometimes tends to be about figuring out the right way to ask the community what they want, and that is somewhat counter to what has been important in my career of building supportive housing because at times no one wants supportive housing, but no one wants homelessness either. Sometimes my job has been to do my work despite what the community wants or convince the community otherwise. Whereas a typical planner's lens is asking the community what they want and try to do that thing. But when it comes to homelessness and mental health and substance abuse it's a little more complicated than that. So, some of the skills of building that support has been incredibly important to me in my career but sometimes I'm coming at it from a different direction. I think that the part of the population that I serve really doesn't have a voice: they're not a member of a community board, they don't show up to meetings, they're not primary voters. They tend to be a little bit hidden from view. Prospective supportive housing tenants, street homeless people, or people who have been deinstitutionalized are not always the best advocates [for themselves] and it's questionable whether using individuals' stories is useful or when it's exploitative. It's a little bit of a different approach than your usual gets all the neighborhood stakeholders together have them do some exercises at round tables, find out what they want, and do that thing. So, I think that planning skill has been very useful to me but sometimes I'm using it despite what the community wants and trying to convince the community what it needs or trying to find that middle ground.

Studies about supportive housing in the community to show the benefits to community. What happens if the community has never seen a supportive housing project? How, as a planner, do you convince them?

> It's pretty retail. That's its whole own conversation. I used to kind of teach seminars on this at the supportive network housing conference each year. Your body language is important, literally what you wear to the meeting is important, and how you behave form the second you walk in the room at a community meeting is important. You don't go to a public forum without already having done a ton of groundwork about building some support or at least getting as much Intel as you can about your opposition. I think it might be different in different cities. I used to work in Boston where the approach was very different. I think New York is great because New Yorkers tell you what they're upset about

form the beginning, they don't try to sugarcoat it or use euphemisms. In Boston, people would complain about the parking or the paint colors or the rear yard setbacks, but you know I could have given them all the parking in the world and that would never address the fact that they didn't want supportive housing their neighborhood but we could never have that conversation head on as often as I would like to. In New York that's not an issue. In New York people will tell you what they do and do not want or do and do not expect in their neighborhood. Which tends to mean a more contentious meeting, but I actually really love that because we're actually having the conversation. So I think keeping your cool in that room, understanding that sometimes, particularly as a city government official I was there to be a punching bag, so don't try to stop people from yelling at you in some cases you let them yell at you in some cases you kind of let the meeting get to sort of a fever pitch and somebody will say something that is kind of outrageous and the rest of the audience will back off. That turning point in a meeting is what you hope for. So, the idea that you want everyone to be calm and quiet in one of those meetings is not necessarily what my goal would be. The contentious meetings are positive because it means people are getting things off their chest, they're letting you know what they're upset about and then you can actually have the conversation head on. A lot of people will question whether or not someone with a substance abuse issue or a mental health issue can live independently. And then we talk a lot about how most of the people with substance abuse or mental health issues do live independently are living independently everybody has somebody in their family who has a substance abuse or mental health issue who lives in an apartment and these just happen to be the folks who don't have one we cannot expect them to overcome those obstacles without giving them an apartment. If I can convince people to go visit a supportive housing project, then I really feel like I'm successful because if they're engaging with me then that means we can really make some progress. People who are willing to go on a tour and have been on a tour of a supportive housing project tend to be much less scared and much less angry. So, when you talk in a meeting in theory about a 100 unit supportive housing project. People have in their head a crowd of 100 homeless men standing on a corner in their neighborhood. But then when you go and visit a project, it's a regular apartment building. And it's pretty quiet and boring, there are a couple of people coming and going, but most of the time, like if I stood in the hallway of my apartment building for an hour you wouldn't see very much and it's the same in a supportive housing project. So, once you get someone to go and see what we're actually talking about I think it really cuts down on some of the fear and the opposition. We found over time, and here's another really good intersection of planning and the behavioral health stuff, the design of the building is really important, so making sure the building can look as great as it can possibly look so really pouring resources into ensuring that it's an asset physically on the street is really critical. That's an important way that we can use design and housing policy intervention to smooth the way for the behavioral health intervention that is supportive housing. Honestly, consistency at those meetings is good, you keep going back over and over again, and the first time you get yelled at and the second time you get yelled at a little less and the third time they already know you. I've given my cell phone out at meetings like that, people get nervous that you're here now but where are you going to be when there's a problem. When that comes up I give out my cell phone number, literally no one's ever called me, but I think people appreciate the idea that I'm in it with them for the long hall. Farming those relationships, people want to know that they can trust you and the only way to do that is to keep showing up. So those are some of the quick hits about how you get people to trust you

> and how you site a supportive housing project. Supportive housing network of New York has a toolkit available online.

I note that the farming relationships is interesting because it applies on both ends of the project; on the supportive housing side they build relationships with the clients who are looking for housing and on the planning side she's building relationships with the community. (She said this was a good parallel! Maybe I am not a totally dummy after all). I asked what she thought about policies on the national level affecting and impacting her work in the field.

> I think what seems to be happening in NYC is that the generation of deinstitutionalized primarily single men, we're either addressing through supportive housing intervention or they're getting older. So, the primary driver of homelessness in NYC today is young single mothers with children. So that calls for a very different approach than the 55-year-old schizoid male that we used to see 20-30 years ago. The face of homelessness is changing a bit, so we're going to need to adjust what are public policy interventions are. I would be curious to see, and I don't know this off hand, how many new - I think there's no longer a huge wave of mentally ill single adult men coming into the shelter system that haven't already been in and out for decades. I think we're starting to chip away at that population. I think the new issue is young families, typically that means a young single mother with young children. So, what do you do with a pregnant woman who shows up at a shelter, is sort of a new major problem. Whereas 15 years ago we were still talking about deinstitutionalized often Vietnam vets with long-term chronic behavioral health problems.

It occurs to me that I missed the opportunity to ask the other professionals a question regarding the logistics of running and developing a supportive housing project. I ask Jessica Katz to explain how supportive housing projects resourced and funded.

> It's different everywhere but in New York it's a combination of the low-income housing tax credit most often (which by the way the new tax bill has severely hampered the value of), some sort of city or state capital, and then as much of a mortgage as you can support. So, a typical supportive housing project can only support about 20% of its capital cost with a conventional mortgage that you pay back and the rest of it has to be subsidized either through tax credit equity or what we call a soft second mortgage from the city or the state, usually both. That's the capital side. Then the rental subsidy has to be paid, there's three buckets of cost: one is the capital, one is rental subsidy, and the third is the social services. The rental subsidy tends to also be covered by the federal government, but it gets harder and harder to fund, so through various programs like the Section 8 program or the Shelter plus Care program which is a federally funded program that is a rental assistance but exclusively for people who are chronically homeless. So as those resources get more and more scarce that becomes more difficult because most supportive housing tenants can't afford the price of an apartment in New York City, even an affordable apartment. So, a public assistance or an SSI check does not get you to the point where you can pay 800 or 900 dollars a month and you need about that much in order for a landlord, even a nonprofit landlord to support the operations of the building so you need a rental subsidy

> otherwise the building will not be well maintained. Then there's the social services funding which comes through the state and the city each have contracts which fund social services through supportive housing. The lay of the land is different in different parts of the country but that's NYC. But everywhere in the country you would need capital, rental subsidy, and social service funding.

This interview was truncated by technical difficulties but before we run out of time I ask Ms. Katz if she has any sage words for a budding planner.

> I think this intersection is a really important place to work and it's one that a lot of people don't want to think about that often. I think, particularly in planning school where you get taught "find out what the community wants" it can be hard to work on behalf of folks who don't have the opportunity to show up to a community meeting and talk about what's best for their community. I think that can be a hard place to work from, but I think for me at least it's been incredibly rewarding to make sure that my job is standing up for people who don't get a chance to participate in civic conversation. I think generally speaking if you're going to do housing policy, it's very hard for me to declare a housing policy victory when there's 1000 people with no place to live in this town. We too easily separate housing policy and homelessness, I've always looked at the purpose my career to make sure those two things are not, that people don't forget to connect those two.

I call this Advocacy Planning in the New Age, to which she laughs and agrees. Speaking with Jessica Katz, despite the brevity has left me considering the planning profession and the ways in which we view our role. In my undergraduate years, where I studied Community Planning we were told we wear many hats as a planner, this was echoed by community development courses taken in graduate school, however I also felt this critical ideology was buried beneath the surface, present but under-recognized, in the program as a whole at Columbia.

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